Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St. Joseph's Hospital
Name of provider:	Health Service Executive
Address of centre:	Lifford Road, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	10 March 2021
Centre ID:	OSV-0000613
Fieldwork ID:	MON-0032300

About the designated centre

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

St. Joseph's Hospital is a designated centre for older people. Residents are accommodated in single and multi-occupancy shared accommodation bedrooms. The centre is divided into four units. The Ash unit can accommodate 25 male and female residents. The Hazel unit is a 32-bedded female only unit. The Alder unit is a 32-bedded, male only unit. The Holly unit is a 12-bedded dementia specific unit. There is a refurbished corridor that links the Ash, Alder and Hazel units with a variety of communal rooms provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Ennis town. Residents have access to enclosed garden area. The centre provides accommodation for a maximum of 101 male and female residents, over 18 years of age. Each resident's dependency needs are regularly assessed to ensure their care needs are met. There is a chapel in the centre and residents have access to the community and a wide range of activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	65

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 10 March 2021	09:30hrs to 17:30hrs	Una Fitzgerald	Lead
Thursday 11 March 2021	10:00hrs to 16:00hrs	Una Fitzgerald	Lead
Wednesday 10 March 2021	09:30hrs to 17:30hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

The centre had a significant outbreak of COVID-19 and at the time of inspection was in recovery. The outbreak was declared as status recovered on the day following the inspection. National level five restrictions impacted on how residents could communicate and interact with family. The restrictions also had a direct negative impact on residents ability to move freely through the centre. While residents were feeling the implications of the COVID-19 outbreak on their daily lives they were quick to state that they felt management were taking all measures to protect them. Residents also had high praise for the staff who care for them on a daily basis.

The centre has four registered units that all operate independently and have a clinical nurse manager who reports to the Director of nursing office. While the Ash and Holly units have communal dining and sitting rooms, the Hazel and Alder units share the communal rooms that are outside of the units.

During the COVID-19 outbreak residents were instructed to remain in their bedrooms and not to mobilise outside of their bedrooms. The communal sitting rooms and dining rooms were all locked on the days of inspection. The impact of this direction on residents meant that they were restricted to remain at their bedside area in multi occupancy bedrooms.

As a result of the pandemic, group activities were all on hold and residents spoken with told inspectors that they found the days very long. On the days of inspection, the activities team were spending time completing one to one activities with residents. Inspectors observed that all grades of staff engaged with residents in a friendly manner. Residents were very happy with the food and choices available. Residents were happy with the length of time it took to have their call bell answered. Residents spoken with were knowledgeable on who was in charge and stated that they would not hesitate to make a complaint.

During conversations inspectors were told by residents that they were not allowed to have showers as a result of the COVID-19 outbreak. Residents spoken with were of the understanding that if assistance was required this meant that the option of a shower was not available for them. Inspectors reviewed the care records and spoke with care staff. Records evidenced that there were periods of months where residents did not have a shower. This was discussed with the nursing management who took immediate action and on day two of the inspection all residents that chose to have a shower were facilitated to have one.

Inspectors spent time in the Holly unit which accommodated residents' with dementia. Bedrooms were personalised with photos and items of personal value. While none of the residents met with were able to tell inspectors their views on the quality and safety of the service, inspectors did observe that the atmosphere was relaxed and welcoming. Residents were content in the company of staff.

The following two sections of the report outline the inspection findings in relation to the governance and management in the centre and how this supports the quality and safety of the service been delivered.

Capacity and capability

The Health Services Executive (HSE) is the registered provider of the centre. The findings of this inspection were that while there was a clearly defined management structure in place the management systems required strengthening to ensure that an effective and safe service was continuously provided for residents.

This was an announced short notice inspection to

- follow up on an application to register an isolation unit for the purpose of a COVID-19 outbreak
- to follow up on the management of infection prevention and control practices in the centre.
- to follow up on unsolicited information received into the Office of the Chief Inspector on infection control in the centre and communication with families.

The centre had four registered units that all operated independently of each other. Each unit reports into the Director of nursing office. The clinical management team consists of a Director of Nursing (PIC), assistant directors of nursing, night sisters, a clinical nurse manager on each unit, staff nurses and a team of multi task attendants. On the days of inspection, there were sixty-five residents and there were sufficient numbers of staff on duty to support resident’s needs. Management meetings and records were kept on clinical related matters for each unit and reported to the Director of nursing office daily. The handover document reviewed was comprehensive and detailed.

On 27 December 2020 the Office of the chief inspector had been notified of a COVID -19 outbreak in the centre. In total, thirty two residents' had been confirmed positive, of these twenty six had recovered and sadly six residents had passed away. The centre had COVID-19 information folders' that contained the most updated guidance. In addition, there was a COVID-19 Contingency Plan that was kept under review and had been updated in March 2021. The person in charge was in ongoing communication with public health officials on the best steps to take in order to protect residents throughout the outbreak. On the days of inspection all residents were remaining in their units and the centre outbreak was declared over on 12 March 2021.

Throughout the outbreak staffing levels were maintained with use of agency staff, these staff worked in this centre only and as a result were familiar with resident needs. There is an ongoing recruitment campaign to fill current vacancies. Inspectors found that the records and system in place relating to training, staff orientation and staff supervision required strengthening. From conversations with

staff and from a review of the records there was an over reliance on existing staff to support and mentor all new staff. Improved induction and supervisions arrangements were required for new staff appointments.

Inspectors followed up on an application made to vary condition one of the registration. The application was for the addition of the Willow unit as an isolation unit. Inspectors examined the unit and found that the unit was not fit for proposed purpose and function. The floor plans submitted were inaccurate. The design an layout of multiple bedrooms did not have appropriate screening and therefore could not ensure residents privacy at all times.

Following the last registration renewal, the centre had a condition applied to the registration that required renovation and reconfiguration of the premises to be completed by December 2021. The building works had commenced and residents from the Alder and Hazel units had been temporarily transferred internally.

However, inspectors found that the Hazel unit had been reopened on the days prior to the inspection when building works were still in progress. Inspectors found that the decision to move residents from the Alder and Hazel units had not been risk assessed to ensure their safety. For example; risk assessment on noise and dust pollution and how to minimise possible negative impact on residents were not available on the days of inspection. There was no signage alerting residents and staff that construction work was in progress which posed a risk of possible injury to both residents and staff. Assurance was requested by the Office of the Chief Inspector following the inspection.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

On 29 January 2021 the centre had made an application to vary condition 1 of the current registration. The application was for the registration of the Willow unit. Inspectors examined the premises and found that the unit was not fit for proposed purpose and function. For example: appropriate privacy and screening for all resident bedrooms was not in place.

Judgment: Not compliant

Regulation 15: Staffing

On the days of inspection, staffing in the centre was adequate for the needs of the residents and the size and layout of the centre. At the height of the COVID-19 outbreak there was a total of thirty two staff unavailable to work. Despite this significant challenge the management team had been able to ensure that there had been sufficient numbers of staff to care for residents needs. The management team confirmed that when staff phone in as unavailable, a replacement is provided if

needed.

Staffing in the centre is supported by the use of agency staff. The centre is registered for 101 and a review of the staffing levels was required to ensure that there are sufficient resources to meet the care needs when admissions recommence.

Judgment: Compliant

Regulation 16: Training and staff development

Training records requested on the day prior to the inspection were not readily available. When the information was provided on day two there were significant gaps in staff training in all areas that are required by the regulations. For example; Inspectors were told that over sixty percent of staff had not completed safeguarding training, twenty four percent had not completed manual handling training.

Judgment: Not compliant

Regulation 23: Governance and management

Improvements were required in the governance and management to ensure the safe delivery of the service. This was evidenced by;

- the decision to move residents back in to a unit when construction works were not complete. This decision did not provide for person centred care. The lack of risk assessment on exposure to dust and noise did not promote a calm safe environment for residents.
- record management required review as staff training records were not easily retrievable. Senior management were not aware of the gaps in training records reported to inspectors.
- there was a comprehensive cleaning and procedures policy dated July 2020. However, inspectors found that failure to adequately implement and monitor adherence the the policy meant that practice was inconsistent and posed a risk to the cleanliness of the premises.
- the management of risk and the system in place to identify, assess, and ensure appropriate follow up required updating, On the days of inspection, the risk to residents associated with the reopening of the Hazel unit were not available.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to accurately reflect:

- the roles and responsibilities of staff in the Statement of Purpose did not align to the certificate of registration.
- a description (either in narrative form or a floor plan) of the rooms in the designated centre including their size and primary function.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The nursing management team were aware of the requirement to notify the Chief Inspector of all incidents as required by the regulations. Notifications as required throughout the recent outbreak of COVID-19 had been submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

The management of complaints required a review. While most complaints were recorded and resolved in a timely manner, improvements were required in overseeing the procedure for recording and resolving complaints. Inspectors were informed of a complaint that had been brought to the attention of the management. Inspectors were informed that appropriate action and engagement with the complainant had occurred. However, the complaint had not been logged.

In addition, inspectors reviewed a complaint that was documented as closed. However, the issue that was reported continued to impact negatively on a resident's daily life and a timely plan to address this issue had yet to be actioned.

Judgment: Substantially compliant

Quality and safety

Residents' lives had been significantly impacted by the COVID-19 restrictions. Overall, inspectors found that the care and support residents received was of a good

quality and ensured that they were well-supported with the exception of the provision of showers and the failure to reassess the requirement for residents to remain in their bedrooms when they had recovered from COVID-19.

Residents' medical and health care needs were met. Staff spoken with were knowledgeable of the signs and symptoms of COVID-19 and knew how to report any concerns regarding a resident. There was ongoing monitoring and observation of temperatures, pulse and oxygen levels which were recorded. Residents care plans were up to date and contained all of the information required to guide care. Inspectors observed staff practice on the days of inspection and found staff adhered to guidance in relation to hand hygiene, maintaining social distancing when possible and in wearing personal protective equipment (PPE) in line with the national guidance. In addition, the management complete daily hand hygiene observation on staff practice.

Infection and control practices in the centre were informed by the Interim Public Health, Infection Prevention and Control Guidance and the centre's own cleaning policy dated July 2020. Each unit had dedicated cleaning staff. Positive Infection prevention and control measures in place included:

- a temperature and COVID-19 symptom check on arrival to the centre
- alcohol hand sanitizers were available throughout the unit.
- appropriate signage was in place reminding all persons to complete hand hygiene and observe social distancing when appropriate.
- there were sufficient supplies of cleaning products
- there were sufficient supplies of PPE
- wash hand basins were sufficiently stocked with hygiene product and paper towels.

Inspectors reviewed cleaning practices in multiple units and found inconsistencies that posed a risk of transmission of infection. For example, staff told inspectors what the correct procedures were for the cleaning of resident accommodation and their bathrooms. Inspectors observed staff were not following their own procedure which posed a risk to the overall standard of cleanliness.

The centre placed a high level of importance on activities and social interaction with residents. The activities staff had been allocated the task to ensure telephone contact with family members on a regular basis. As a result of the COVID-19 pandemic all group activities were on hold. However, the resources allocated to activities and meaningful individual one to one activities for residents had been maintained. While the days were long, residents told inspectors that staff did engage with them on a social level and that interactions did occur outside of the direct delivery of care.

Inspectors observed multiple one to one activities occurring throughout the days of inspection. Multiple residents had activity folder at their bedside fill with puzzles and paper based activities. The activities team had developed a "preventing social isolation activities" plan. The schedule included one to one activities, exercise via intercom, bingo in individual pods, individual radio requests with local radio and

mass was streamed daily. In addition, residents were seen using electronic devices to look up the Internet and keep themselves informed on topics of interest to them.

Regulation 17: Premises

At the time of inspection there was significant building works in progress in the Hazel and Alder units. As a result, residents had been relocated to units within the building. Inspectors found that this movement had had a negative effect on residents.

The works on the Hazel Unit were in progress and presented risk of injury to residents due to:

- the corridor along which the old part of the building meets the new extension was not signposted to alert residents that works were taking place
- resident bathrooms and shower for communal use were at the end of this corridor and so 24 hours safe access was required.This meant residents had to travel past the partition to their facilities
- the partition was not sufficiently braced
- the presence of the partition, the width of the corridor did not allow for staff to walk alongside residents' to provide assistance. In addition, the corridor was noted to be dark which posed a falls risk
- the area in front of bathrooms and shower had an accumulation of clay and dust
- noise from drills was heard on the days of inspection

Inspectors reviewed an application to vary Condition 1 to accommodate residents on the Willow unit for isolation purposes. The unit was not fit for proposed purpose due to:

- inadequate storage space for residents
- lack of privacy screens in bedrooms
- inadequate sitting, recreational and dining space other than a resident's private accommodation as required by regulations
- floor plans were not accurate. For example: the bedroom numbers and the purpose of some rooms did not align with the floor plans
- assurances were required on fire safety matters which were not available on the day of inspection. Fire floor plans displayed were dated 2014.

Judgment: Not compliant

Regulation 27: Infection control

Systems in place for the oversight and review of infection prevention and control

practices required a review. While the centre had a comprehensive policy in place, improvements in practice was required. For example: inspectors were told that the centre had introduced a flat mop colour coded system for the cleaning of floors. Not all staff were following the new system. Practices varied between units.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A care plan had been developed, following an admission assessment, for each resident in the centre within 48 hours of their admission. Validated nursing assessment tools were used to assess, for example, nutrition, dependency, pain, falls risk and use of bedrails and were updated accordingly. Inspectors reviewed a selection of care plans and found that the majority contained the necessary information to guide care. Residents' weights were monitored and appropriate interventions were in place to monitor and address changes.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to access allied healthcare services in the centre. Inspectors reviewed resident records that evidenced access to Medical Officers throughout the pandemic and the COVID-19 outbreak. One resident spoken to detailed their experience of individual physiotherapy sessions and support from staff that had helped them regain function of their dominant hand following a cardiovascular accident.

Residents' were supported to access National Screening Programme and other allied healthcare services such as physiotherapy, occupational therapy, chiropody, dietitian, audiology and optician services. However, while staff had made efforts, there was evidence that access to dental services was not available and this had had a negative impact in one file reviewed. The PIC assured inspectors that this would be followed up post inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Notwithstanding the social and environmental restrictions in place during the

outbreak, inspectors found that decisions made on the movement of residents' between units had not been appropriately assessed for the impact the decisions were having on the residents. For example; a resident told inspectors that they were not permitted to leave the unit. The decision had not been reassessed throughout the entire period of isolation which commenced on the 27th December 2020, the last positive case of COVID-19 was the 28th February 2021.

In the multi-occupancy rooms there were up to four residents sharing accommodation. In one room inspectors observed a resident with responsive behaviour that was calling out at frequent intervals. This calling out was distressing to another resident sharing the room. A resident told inspectors ''I cannot hear myself thinking''.

Residents rights and dignity was not always promoted. In the dementia unit a decision had been made to close the communal bathroom and use the bathroom temporarily as storage. This meant that residents who did not have ensuite facilities were been showered in the ensuite bathrooms of other resident bedrooms.

The failure to respond to residents need in respect of provision of regular showers did not allow residents to exercise choice.

Judgment: Not 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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St. Joseph's Hospital OSV-0000613

Inspection ID: MON-0032300

Date of inspection: 11/03/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: Actions Complete: • In the interim appropriate privacy and screening was reviewed and risk assessed for all resident's bedrooms. This has been actioned in the form of blinds, curtains and window screening. Actions in progress: • Application to vary of the current registration, Condition 1, Willow Unit, will not be advanced, therefore will be withdrawn • Statement of Purpose and floor plans have been amended to reflect this	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Actions Complete: • A full review of the training portfolio has been completed by the Development Officer, Older Persons Residential Services, in collaboration with the Practice Development Officer, Director of Nursing and Assistant Director of Nursing • The agreed process is that one of the Assistant Director of Nursing will provide	

oversight and coordination of the training portfolio. This has been discussed and communicated with all Clinical Nurse Managers.
• The training matrix is now a live document and is accessible by the Director of Nursing, Assistant Director of Nursing and Clinical Nurse Managers on a shared folder.
• Training is a standing item on the agenda for the weekly meeting with Director of Nursing/Assistant Director of Nursing and bio monthly meeting with Assistant Director of Nursing /Clinical Nurse Managers.
• The Clinical Nurse Managers will provide assurance to the Assistant Director of Nursing that training requirements are being progressed
• This process is discussed and commenced at orientation and subsequent site induction by the line manager
• Training Matrix has been updated and cross referenced with evidence of staff training certification.
• All Units have up-to-date training matrix available.
• 42 staff have completed cleaning system training up to the 13th April 21. Further rolling dates to be confirmed for all units.
• Cleaning check list is completed daily by the staff. This is then checked and signed by the Clinical Nurse Manager/ Nurse in charge.
• Fire training complete 26th March 2021 with 40 staff attended, further dates for fire training are April 22nd 29th and May 6th 2021.
• Currently 78% of staff have completed the Safeguarding training
• HSEland training for manual handling training has commenced, this will be supported by practical training dates scheduled for 28th April, 11 & 20th May 2021

Actions in progress:

• Training is a standing item on the agenda for the Clinical Nurse Manager bio monthly meeting. Oversight is provided by an Assistant Director of Nursing.
• Restraint training is being facilitated and is scheduled for 17th & 26th May 2021.
• BLS training dates are April 6th, 13th, 19th & May 4th 2021.
• Manual handling training is scheduled for 28th April, 11 & 20th May 2021
• Complaints Management Training will be facilitated by Complaints Manager, scheduled for 15th &16 April 2021.
• Cleaning system training provider has been contacted in order to schedule training dates to be confirmed
• All mandatory training e.g. Safeguarding, Infection Prevention & Control HSEland training, is being progressed by the Clinical Nurse Managers at Unit level for all staff. Oversight provided by Assistant Director of Nursing.

Regulation 23: Governance and management	Not Compliant

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

Actions Complete:

• The decision to move residents back in to a unit when construction works were not complete was discussed with senior management and reviewed.
• A Health and safety visit was facilitated by the HSE Health & Safety Officer, QRPS, on 16 March 2021.
The following Risk assessments were complete by the Director of Nursing in collaborating with Quality Risk & Safety Advisors on 16 March 2021
1) Risk of injury to residents due to the presence of the partition structure in the Hazel Unit, which reduces the space available to residents and makes the journey to their toilet hazards
2) Harm to Person- Risk of injury discomfort and or ill health to staff and residents while occupying Hazel Ward for the remainder of the construction works on Hazel Ward
3) Service User Experience- Risk of injury discomfort and or ill health to staff and residents while occupying Hazel Ward for the remainder of the construction works on Hazel Ward
4) Risk of noise associated with the building works being completed on the Hazel Unit while the residents are present - Risk of injury discomfort and or ill health to staff and residents while occupying Hazel Ward for the remainder of the construction works on Hazel Ward.
• The risk assessment has been updated on the designated center risk register.

Subsequent to the aforementioned risk assessments the following control measures were addressed:

Actions completed on 16 March 2021:

• The corridor along which the old part of the building meets the new extension is now signposted to alert residents and staff that works are taking place
• 24-hour safe access has been secured for communal bathrooms and showers
• The partition has been sufficiently braced
• The width of the corridor now allows for staff to walk alongside residents to provide assistance
• The corridor has 24 hour led lighting as a control measure in the prevention of falls risk
• The area in front of the bathrooms and shower was cleared of clay and dust. This is now included on the cleaning schedule
A noise pollution risk assessment was completed with existing and additional controls identified
The Management and Risk Policy is being discussed at Safety Pause and handover by each Clinical Nurse Manager per unit. Staff roles and responsibilities are discussed at staff orientation, induction and subsequent unit staff meetings
• Baseline residents experience survey to assess the impact of relocation on residents wellbeing was commissioned and completed on 17th March 2021
• A full review of the training portfolio has been completed by the Development Officer, Older Persons Residential Services, in collaboration with the Practice Development Officer, Older Persons Residential Services, Director of Nursing and Assistant Director of Nursing
• The agreed process is that one of the Assistant Director of Nursing will provide oversight and coordination of the training portfolio. This has been discussed and

communicated with all Clinical Nurse Managers.
• This process is discussed and commenced at orientation and subsequent site induction by the line manager
• The Clinical Nurse Managers will provide assurance to the Assistant Director of Nursing that training requirements are being progressed
• Training Matrix has been updated and cross referenced with evidence of staff training certification.
• All Units will have up-to-date training matrix available via the shared folder.
• Training both mandatory and non-mandatory is being progressed via internal/external facilitators, CNME and HSEland and populated on the training matrix.
• Implementation, compliance and monitoring of the HSE Cleaning Policy, July 2020 is being led by Clinical Nurse Managers per unit.
• The HIQA Self-Assessment Infection Prevention & Control Tool, Sept 2020, has been populated to ensure Infection Prevention & Control standards
• Supervision is being provided on each unit by the Clinical Nurse Manager.
• Oversight & monitoring is being provided by the Assistant Director of Nursing per unit and escalating areas of improvement to the Director of Nursing.
• A daily Quality & Safety report is submitted by each unit Clinical Nurse Manager to the Assistant Director of Nursing Office.
• Audit of environmental cleaning is provided monthly by Clinical Nurse Manager to the Assistant Director of nursing office.
• The Hazel Works have been completed 12th April 21.

Actions in progress:

• The Contingency Plan is a dynamic document and updated as required

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Actions Complete:
The Statement of Purpose has been reviewed and revised:
• The roles and responsibilities of staff outlined in the Statement of Purpose are accurately reflected in the Certificate of Registration.
• Estate Department have scheduled an onsite site visit to revise the floor plans
• The Statement of Purpose for the Designated Centre now contains the floor plan of the rooms inclusive of their size and primary function.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Actions completed:

• In line with HSE complaint management policy the management and logging of complaints at the Designated Centre has been reviewed
• The policy and adherence to the process of complaint management and logging of complaints has been discussed at a meeting held with the Senior Nurse Management Team on 30 March 2021
• Compliments and complaints are now logged separately.
• The HSE complaint policy, "Your Service, Your Say", is made available to the resident/families/nominated representative on pre admission and discussed further on admission.
• Residents are reminded at the residents' forum meetings that they can make a complaint to any member of staff at any time. The complaint policy and procedure is followed.
• The Assistant Director of Nursing is the complaint officer in the designated centre.

Actions in progress:
• Complaints Management Training will be facilitated by HSE Complaints Manager, QRPS, scheduled for 15th &16 April 2021.
• Further supportive training on complaints management is being progressed by the Clinical Nurse Manager at Unit level for all staff.
• A complaint reviewed by HIQA Inspectors documented as being closed. This has been reviewed and a timely action has been put in place.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Actions Complete:
Risk assessments were complete by the Director of Nursing in collaborating with Health & Safety, Quality Risk & Safety Advisor on 16 March 2021
1) Risk of injury to residents due to the presence of the partition structure in the Hazel Unit, which reduces the space available to residents and makes the journey to their toilet hazards
2) Harm to Person- Risk of injury discomfort and or ill health to staff and residents while occupying Hazel Ward for the remainder of the construction works on Hazel Ward
3) Risk of injury discomfort and or ill health to staff and residents while occupying Hazel Ward for the remainder of the construction works on Hazel Ward
4) Risk of noise associated with the building works being completed on the Hazel Unit while the residents are present - Risk of injury discomfort and or ill health to staff and residents while occupying Hazel Ward for the remainder of the construction works on

Hazel Ward.

Subsequent to the aforementioned risk assessments the following control measures were addressed:

Actions complete on 16 March 2021:
• The corridor along which the old part of the building meets the new extension is now signposted to alert residents and staff that works are taking place
• 24-hour safe access has been secured for communal bathrooms and showers
• The partition has been sufficiently braced
• The width of the corridor now allows for staff to walk alongside residents to provide assistance
• The corridor has 24 hour led lighting as a control measure in the prevention of falls risk
• The area in front of the bathrooms and shower was cleared of clay and dust. This is now included on the cleaning schedule
• A noise pollution risk assessment was completed with existing and additional controls identified
• The application to vary Condition 1 to accommodate residents on the Willow Unit for isolation purpose has been withdrawn. The Designated Center COVID 19 contingency plan has been reviewed and updated.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Actions complete:

• The flat mop color coding system for the cleaning of the floors has been discussed at unit level by the Clinical Nurse Manager and adherence to same is supervised by the Clinical Nurse Manager
• A full review of the Infection Prevention & Control training portfolio has been completed by the Development Officer, Older Persons Residential Services, in collaboration with the Practice Development Officer, Director of Nursing and Assistant Director of Nursing
• The agreed process for the Infection Prevention & Control training is that one of the Assistant Director of Nursing will provide oversight and coordination of the training portfolio. This has been discussed and communicated with all Clinical Nurse Managers.
• Infection Prevention & Control training is a standing item on the agenda for the weekly meeting with Director of Nursing, Assistant Director of Nursing and bi-monthly meeting with Assistant Director of Nursing & Clinical Nurse Managers.
• The Clinical Nurse Managers will provide assurance to the Assistant Director of Nursing that Infection Prevention & Control training requirements are being progressed
• This process of Infection Prevention & Control standards & HSE Cleaning Policy, July 2020 is discussed at orientation and subsequent site induction by the line manager

• Monitoring of the application of the HSE Cleaning Policy, July 2020 is by the Clinical Nurse Managers
• Currently 25 staff have completed cleaning system training on 22.03.2021.

Actions in progress:
• Cleaning system training provider has been contacted in order to schedule training, dates to be confirmed
• Adherence to HSE Cleaning Policy, July 2020 is supervised by the Clinical Nurse Manager in all units
• Audit of environmental cleaning is provided monthly by Clinical Nurse Manager to the Assistant Director of nursing office.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Actions complete:
Resident's rights and dignity are promoted at the designated center, both individually and at a broader level residents are informed pre admission, on admission, at unit level and during resident's forums, e.g. advocacy service, Confidential Recipient, 'Your Service Your Say', safeguarding issues.
• The learning from the period of isolation have been discussed and shared at staff meetings and also the residents forum
• Baseline residents experience survey to assess the impact of relocation on residents wellbeing was commissioned and completed on 17th March 2021
• Residents are mobilizing external from the units to the communal areas and chapel
• The residents social care assessments have been reviewed and care plans updated
• Responsive behavior assessments have been complete and care plans updated
• Group activities are facilitated within the residents pods, and in compliance with National Guidelines
• The storage in the communal bathroom in the dementia unit has been relocated, this ensures that all residents have accessible and appropriate bathroom and showering facilities
• An audit on the personal care/hygiene care practice for each individual resident was completed in March 2021
• The audit results have been shared with all unit staff
• In response to the audit a Quality Improvement Plan was developed in collaboration with the unit Clinical Nurse Managers on 17th March 2021
• Visiting recommenced on the 22ND March 2021 as per the HSE Covid 19 guidelines.

Actions in progress:
• A rolling audit on the personal care/hygiene care practice for each individual resident has been scheduled bi-monthly for three months.
• Oversight is the responsibility of the Assistant Director of Nursing in collaboration with the Clinical Nurse Manager

• The Quality Care Metrics is scheduled monthly by the Clinical Nurse Managers. Feedback is provided at the unit meetings and Quality Improvement Plan developed and implemented by the unit Clinical Nurse Manager

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
Registration Regulation 7 (2)	An application under section 52 of the Act must specify the following: (a) the condition to which the application refers and whether the application is for the variation or the removal of the condition or conditions; (b) where the application is for the variation of a condition or conditions, the variation sought and the reason or reasons for the proposed variation; (c) where the application is for the removal of a condition or conditions, the reason or reasons for the proposed removal; (d) changes proposed in relation to the	Not Compliant	Orange	15/04/2021

	designated centre as a consequence of the variation or removal of a condition or conditions, including: (i) structural changes to the premises that are used as a designated centre; (ii) additional staff, facilities or equipment; and (iii) changes to the management of the centre that the registered provider believes are required to carry the proposed changes into effect.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Yellow	31/05/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/04/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	15/04/2021

Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	24/04/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	15/04/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	15/04/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	15/04/2021
Regulation	The registered	Substantially	Yellow	15/04/2021

34(1)(e)	provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall assist a complainant to understand the complaints procedure.	Compliant		
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Substantially Compliant	Yellow	26/04/2021
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	12/03/2021