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:	Ramelton Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Ramelton, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	04 August 2022
Centre ID:	OSV-0000615
Fieldwork ID:	MON-0035201

About the designated centre

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

Ramelton Community Hospital is a designated centre registered to provide health and social care to 30 male and female residents primarily over the age of 65. It is a single storey building a short drive from the shops and business premises in the town. Accommodation for residents is provided in single and double rooms and there are several communal areas where residents can spend time during the day.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 4 August 2022	10:00hrs to 17:45hrs	Nikhil Sureshkumar	Lead

What residents told us and what inspectors observed

Overall, those residents who spoke with the inspector were positive about the care and support provided by the staff in the centre. However, a number of residents told the inspector that the arrangements that were in place to support their social care needs were insufficient and that there were not many activities happening in this centre to keep them occupied. The findings of this inspection validated the feedback from residents in relation to the lack of opportunities for residents to engage in meaningful activities in line with their interests and abilities. These were repeated non-compliances from the previous inspection.

The centre is located near Ramelton and is close to local amenities. The centre can accommodate 30 residents in a mix of single and twin-bedded rooms, and there were 21 residents accommodated on the day of inspection, which included long and short-stay residents.

Following the introductory meeting with the person in charge, the inspector went for a walk around the centre. The inspector noted that the reception area was also used by the general public attending the physiotherapy outpatient department, which was located in the same building but was not part of the designated centre. This created an unacceptable risk to residents as the members of the public attending the physiotherapy department had access to some of the residents' areas, including the reception area where some residents chose to sit.

Even though long corridors connected the centre's various sections, some of the doors leading to the corridors were keypad locked. This meant that staff assistance was required for the residents to access areas such as the reception and the dining room. This was an overly restrictive practice and meant that residents were only able to access the dining room at meal times. The dining room was a pleasant space that overlooked the entrance to the building and the road outside the designated centre. Some residents told the inspector that they would like to be able to sit in this area to watch what was happening outside but said that they were not able to access the area outside of meal times.

During the walk around, the inspector noted that the centre's physical environment was in a poor state of repair and decoration and that the provider had failed to provide the resources to complete the action plan following the previous inspection. The walls and skirting board in communal areas were visibly damaged. The centre was visibly dirty in a number of areas. For example, the inspector noted that dirt and grit accumulated in cracks and small holes in the floor linings in several bedrooms and clinical areas and along the corridors of the building. Overall, the atmosphere of the centre was dull and lacked colour and interest. This was a repeated finding from the previous inspection. In addition, the inspector observed that the doors of some rooms were not closing properly, and this had not been identified by staff, and as a result, the doors were not scheduled for repair.

The inspector found that the corridors were adequately lit and well-ventilated, and the temperature of the centre was comfortable for the residents. There were handrails located along the corridors throughout the building, however, the inspector observed that unused equipment was stored along some corridors and in communal rooms, which prevented the residents from being able to use handrails safely. This arrangement posed a risk of injury to residents who accessed these areas.
There were no dedicated storage areas identified to store equipment in the centre, and a bedroom was utilised to store unused equipment. This is a repeated finding from the previous inspection.

The centre has two-day rooms, which were located in the inner part of the building. The inspector spent time in the day room and noted that the staff interactions with residents were kind and respectful. However, the inspector noted that the staff and resident interactions were mostly task-oriented and brief. As a result, the residents spent long periods of time without any social engagement either with staff or with each other. Some residents told the inspector that they often felt lonely in the centre.

The inspector noted that the communal areas were noisy, with the sound of chair alarms frequently activated to alert staff to attend to the day rooms when residents stood up or attempted to move away from their chairs. This was an overly restrictive practice, especially as there were enough staff on duty to allow staff to be present in the day rooms to engage with residents and supervise the movements of those residents who may be at risk of falls. In addition, the inspector noted that the ambience of the communal room did not support the residents to relax and enjoy their time in the day room. This was validated by residents, some of whom were trying to read the newspapers or watch the television. Residents informed the inspector that the frequent noise from the chair alarm bells is an annoyance for them as they could not focus on what they are interested in doing.

The inspector observed that during the morning, one to one physiotherapy sessions were made available for those residents who required support for their mobility. Some of these sessions were held in the corridors and in the communal rooms, which meant that the resident did not have privacy whilst they were working with the physiotherapist.
Physiotherapy sessions were the only activity offered to residents on the day of the inspection. There was no activities schedule available, and staff were not allocated to provide activities in line with the residents' preferences and capacities.

The inspector visited some of the bedrooms and noted that privacy curtains were provided in multi-occupancy rooms, which supported the privacy of residents accommodated in these rooms. Televisions were available in the bedrooms, and some residents were observed enjoying the television in their rooms. Residents had sufficient space to store their personal belongings. However, the inspector found that the layout and design of single bedrooms did not support the needs of the residents with higher dependencies in the centre because the size and layout of these rooms made it difficult for residents to access their hand washbasins without moving furniture and the rooms did not facilitate the use of assistive equipment

such as hoists and large comfort chairs. The inspector observed that even though several vacant rooms with en suite facilities were available in the centre on the day of inspection, a resident with a high level of mobility needs was accommodated in a single room that was not suitable for them.

The inspector spent time in the dining areas of the centre and noted that the dining room of the centre has seating arrangements to support ten residents at a time. Menus were displayed at each table, and dining tables were nicely set out with appropriate cutlery and condiments. However, only those residents who needed minimal assistance were facilitated to eat in the dining rooms. Those residents who needed one to one support at meal times were not offered a choice to eat in the dining room and enjoy the shared social occasion with other residents. These residents ate in their bedrooms or on tables set out along the link corridor or in the communal day rooms. These tables did not have menus displayed, and residents who spoke with the inspector did not know what was on the menu at lunchtime. Some of these residents told the inspector that they would prefer to eat in the dining room but that they were not offered that choice. Furthermore, the inspector observed that there were not sufficient staff allocated to support the residents in these areas at meal times.

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

Overall, the inspector found significant focus and effort were now required to bring this designated centre into regulatory compliance and to ensure that the care and services provided for the residents were safe and of good quality. It was clear on this inspection that the provider had failed to take the actions set out in their compliance plan to fully address the non-compliances identified in the previous inspection in July 2021.

The Health Service Executive (HSE) is the registered provider for the designated centre. As a national provider providing residential services for older people, the designated centre benefits from access to and support from centralised departments such as human resources, accounts and information technology. The designated centre had clear management structures in place that identified the lines of authority and accountability. The provider had appointed a person to represent them, and the person in charge of the centre facilitated this inspection.

This risk-based unannounced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector reviewed the actions from the compliance plans of the last inspection and the information submitted by the

provider and the person in charge.

Even though improvements were made in relation to the fire safety issues identified on the previous inspection in the centre, the fire stopping of the ceiling, which was considered as an amber rated risk issue by the provider's competent person, had not been adequately addressed and the actions to address a number of amber rated fire risks had not been completed. In addition, the provider had failed to inform the Chief Inspector regarding the delays in carrying out the outstanding fire safety works in line with the compliance plan that had been submitted following the previous inspection. During the inspection, the person in charge informed the inspector that arrangements were made on the day of the inspection to commence the outstanding fire safety works the first week of September 2022.

In addition, the inspector found that the provider had not taken the actions required to ensure that all residents in the centre were provided with the facilities and opportunities to engage in meaningful activities and social interactions in line with their preferences and capacities. Many residents reported that they felt bored in the centre and did not have access to their favourite television programmes, including a stable Internet connection to source these programs.

The person in charge reported a number of staff vacancies on the day of the inspection. The staff vacancies reported by the person in charge included vacancies for an activities coordinator, a chef, and a nurse manager. Although records showed that the chef vacancy was being covered by agency staff, the other vacancies were not being covered. In addition, the inspector noted that arrangements were not made to fill an unplanned staff absence on the day of inspection. In spite of the vacancies, the inspector found that there was sufficient staff on duty on the day of the inspection, nevertheless, staff were not effectively utilised to provide key areas of care such as the provision of social care activities, assisting residents at meal times and supervising residents in the communal rooms. This impacted on the quality and safety of residents on the day of the inspection, as described in this report.

Furthermore, staff supervision in the centre required significant improvement to ensure that the residents were provided with care in accordance with their assessed needs. Several residents who were assessed as at risk of developing pressure ulcers and required to be repositioned at frequent intervals were not provided with the prescribed care in line with their care plans.

In addition, the cleaning supervision in the centre required improvement to ensure that the standard of cleaning was carried out to a high standard. The centre has a cleaning schedule containing a checklist, however, these checklists were not completed for a number of days, and this had not been identified by the management team. As a result, the centre was found to be visibly dirty in several areas, which was not in line with the infection prevention and control standards set out for community health services by the Authority.

The inspector found that although staff were knowledgeable of the safeguarding arrangements in the centre, the staff practices observed on the day did not provide

assurances that the safeguarding training was effective. For example, one resident had raised a safeguarding concern about an incident that had occurred with a member of staff. Records showed that the incident had not been followed up in line with the centre's own safeguarding procedures, and the chief inspector was not notified about the incident. The relevant notification was requested to be submitted to the Chief Inspector and was submitted following the inspection. This is further discussed under the quality and safety section of the report.

Staff had access to an ongoing training programme. Records showed that some staff were overdue for the mandatory fire safety training on the day of inspection, and the provider had made arrangements to facilitate the training prior to this inspection.
Records showed that there was a system to monitor the accidents and incidents that occurred in the designated centre, however, the action plans and learning from the incident were not available to inspect on the day of inspection. In addition, an annual review of the quality and safety of care delivered to residents for 2021 was not carried out in the centre and was not available to inspect on the day of inspection.

The inspector noted that the centre has a complaint procedure and policy in place. Residents who spoke with the inspector were knowledgeable about the complaint process. However, the centre's complaint procedure did not provide adequate oversight of the complaint management process. For example, even though the complaints were recorded in the complaint log of the centre, the records of the investigation of the complaint and the outcome of the investigation were not available in the centre. In addition, the satisfaction of the complainant was not recorded in the centre's complaint log.

Regulation 15: Staffing

The provider had kept the staffing resources of the centre under review, and the rosters reviewed on the day of inspection evidenced that there was a nurse on duty at all times in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised according to their role to ensure that the care provided to the residents was safe and based on their assessed needs and that the service provided in the centre was effective. For example:

- The inspector observed that a resident appeared unkempt and did not receive appropriate personal care on the day of the inspection. This had not been

identified by nursing staff until the inspector raised the issue with the person in charge.

- Staff were not appropriately supervised when assisting residents at meal times. For example, the inspector witnessed a member of staff standing over a resident while they were assisting the resident with their meal. This meant that the resident was not able to keep eye contact with the member of staff in order to communicate their needs or levels of satisfaction with the meal. In addition, this staff behaviour did not promote the dignity of the resident for whom they were providing care.
- The cleaning supervision in the centre required improvement to ensure that the centre is cleaned to a high standard. There were several gaps in the centre's cleaning schedule which could not be explained by the management team.

Judgment: Substantially compliant

Regulation 21: Records

The inspector reviewed a sample of records and noted that the records required under Schedules 2 and 3 of the regulation were available for the inspectors to review.

Judgment: Compliant

Regulation 23: Governance and management

Even though there were management systems in place, the quality assurance systems did not ensure that the care provided in the centre was safe and effective. For example:

- Even though the rooms that stored equipment and harmful chemical were fitted with keypad locks on its door, they were not locked at all times. As a result, they posed an injury risk to those residents who accidentally accessed these areas.
- Even though care plan audits were carried out in the centre, they were not effective in identifying the issues the inspector identified on the day of inspection.
- While weekly and daily checks were carried out to review the centre's fire precautions, they were not effective in identifying the issue with the automatic door-closure devices in some rooms. For example, the door closure of a door in a room which was used to store three oxygen cylinders were not working properly. As a result, the door did not close properly to create a tight seal to ensure effective compartmentation. On the day of inspection, the

inspector noted that the staff had to manually close the door on several occasions.

- While the centre had a centralised system to analyse all the recorded accidents and incidents in the centre, they were not effectively utilised in developing action plans and improving the quality of the service in the centre. For instance, while a breakdown of the accidents incidents in the centre was available in the centre, one resident with responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) did not have an effective safeguarding care plan.
- In addition, post-fall reviews in the centre had not identified the need for staff supervision in day rooms.

In addition, the resources available in the centre were not utilised appropriately to provide optimal delivery of services. For example:

- The existing dining room arrangements were not utilised appropriately to promote choice for the residents and to ensure all residents who wished to use the dining room at meal times were able to do so.
- While several en-suite facilities were vacant on the day of inspection in the centre, a resident with higher dependencies and who had expressed a wish to be accommodated in a room with a toilet close by had not been offered one of the vacant en suite rooms.
- Staff were not appropriately allocated to ensure that the needs of the residents were always met. For instance:
    - There was insufficient staff available in the day room to supervise residents and meet their needs.
    - The provider had failed to ensure that appropriate resources were allocated to ensure that residents could engage in meaningful activities in line with their preferences and capacities.
    - The provider had failed to provide the resources that were required to decorate and maintain the premises to a good standard.
    - The provider had failed to provide the resources to complete the fire safety works required in the centre to bring the premises into compliance with Regulation 28.

The provider had not carried out an annual review of the service provided in the centre for 2021 and was unavailable in the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had reviewed and revised the statement of purpose and the up to date statement of purpose was available in the centre at the time of

inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had not notified in writing of a safeguarding incident within three working days of its occurrence to the Chief Inspector. The person in charge submitted the notification following the inspection.

In addition, the provider had not notified the Chief Inspector regarding the use of door locks in the centre as restraints as required under Regulation 31.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had not ensured that the nominated person maintained a record of all complaints, including details of any investigation into the complaint, the outcome of the complaint and whether or not the complainant was satisfied with the outcome of the complaint. For example,

- the record of the investigation of complaints was not available in the centre
- the outcome of the complaint and the complainants' satisfaction were not recorded in the centre's complaint log.

In addition, the provider had not nominated a person to oversee the complaints management process so as to ensure that the complaints were responded to appropriately and in line with the regulatory requirement.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Policies and procedures on the matters set out in Schedule 5 were reviewed at appropriate intervals and were made available to staff in the centre.

Judgment: Compliant

Quality and safety

Overall, significant improvements were required to ensure that the residents' rights were upheld in the centre and the service provided to the residents was safe, consistent and appropriate.

The inspector noted that the centre's internal premises were not maintained to a high standard. The building was in a poor state of repair, and repainting was not carried out to maintain the decor of the internal premises. There were scuff marks on the walls and skirting in the corridors and communal areas. The residents living areas were dull and lacked interest, and the inspector noted that several high-touch surfaces did not support effective environmental cleaning. The floor lining in many areas, including residents' bedrooms, was cracked, and some areas had holes which accumulated dirt and grit. These were repeated findings from the previous inspection. In addition, the inspector noted that the centre did not have sufficient clinical wash hand basins at an appropriate location for the staff to perform effective hand hygiene

There was no dedicated storage area in the centre to store equipment when not in use. Equipment such as assistive chairs and frames were being stored in an un-locked bedroom, this cluttered the room and meant that the room could not be cleaned. In addition, equipment was being stored along the corridors and in communal areas of the centre. This posed a potential risk as residents could trip or fall whilst trying to mobilise around this equipment. This issue was highlighted in the previous inspection, and the provider had not taken the necessary actions to improve the storage of the centre.

In addition, the inspector noted that the layout and design of the single bedrooms did not meet the needs of residents with higher dependencies. There was minimal space in the single bedrooms, and as a result, there was not enough room to facilitate the safe moving and handling of residents, especially those residents who needed to use assistive equipment. Moreover, the room space did not allow for a comfortable chair beside the bed so that residents could comfortably sit out next to their beds. In addition, the positioning of the television in some rooms made it difficult for the residents to comfortably watch their favourite programs. The small size of some of these bedrooms meant that the resident's comfortable chair was placed close to the hand-wash basins, which made it difficult for the residents to access the hand-wash basins to wash their hands or to get themselves ready for bed. This was verified by feedback from a resident who told the inspector that the layout of their room did not support their needs, and the positioning of the chair near the wash hand basin made it difficult for them to have a wash or to wash their hands

The inspector spoke with a number of staff and noted that they were knowledgeable of the centre fire evacuation procedures. This was an improvement from the previous inspection. However, even though the fire procedures and personal evacuation plans of the residents were available in the unit, they were not stored

where they could be easily accessed in the event of a fire.

While the fire drills were carried out regularly, the records maintained were not sufficiently detailed to provide assurances to the inspector that the residents could be safely evacuated to a safe location in the event of a fire. This is a repeated finding from the previous inspection. The person in charge carried out a simulated fire drill, and a satisfactory report was submitted to the inspector following the inspection.

In addition, the inspector noted that the provider had not completed all of the necessary fire safety works in line with their own fire safety risk assessment and the previous inspection's compliance plan. This is further discussed under Regulation 28.

While some improvements were noticed in the management of residents' medication, further improvements were required to ensure that the storage and disposal of outdated and unused medications were safely carried out to prevent drug errors in the centre.

The inspector reviewed a sample of care plans and nursing assessments in the centre and noted several improvements from the previous inspection. However, further improvements were required to ensure that the residents' care plans were person centred and contained sufficient detail in relation to each resident's current needs. The inspector also found that some improvements were required to ensure that the residents were appropriately assessed and timely medical care was arranged to meet their assessed needs. This is further discussed under Regulation 6.

Overall, the inspector noted that the staff were found busy attending to the care needs of the residents, and many residents commented that the staff were excellent in performing their duties and were very friendly towards them.

Staff who spoke with the inspector were knowledgeable about the safeguarding arrangements in the centre. However, improvements were required to ensure that the accidents and incidents related to an allegation of abuse in the centre are identified and appropriately investigated. This was essential to develop an appropriate safeguarding plan for the residents in the centre

The inspector noted that significant improvements were required to ensure that the residents' social care needs were supported in the centre, and this is a repeated finding from the previous inspection. The residents were not provided with opportunities to engage in meaningful activities based on their preferences and capacities, and many residents reported that they felt bored and that their days were long in the centre. In addition, the arrangements in the centre did not ensure that the residents could independently access the outdoor areas of the centre. This is further discussed under Regulation 9.

Regulation 12: Personal possessions

Residents were supported to maintain control of their clothing and personal belongings. Residents had adequate storage space in their bedrooms, including a lockable space for their valuables if they wished.

Judgment: Compliant

Regulation 17: Premises

The premises of the centre did not conform to the matters set out in Schedule 6 of the regulation, and this is a repeated finding from the previous inspection. This is evidenced by:

- The arrangements for storage were not sufficient. For example, hoists and comfort chairs were stored in the corridor, which obstructed residents' access to handrails. Assistive devices, such as hoists were stored in the communal day room and a bedroom was being used to store equipment that was not in regular use.
- The premises were in a poor state of repair and decor. For example, the floor linings, walls and ceiling of corridors and some bedrooms were visibly damaged.
- The premises was in a poor state of decoration and required repainting and refurbishment.

The layout and design of some bedrooms were not appropriate to the needs of the residents. For example:

- The single bedrooms of the centre did not have enough space for a comfortable chair beside the bed without blocking access either to a wardrobe or the wash hand basin.
- The layout of some of the single bedrooms was not suitable for residents with higher dependencies.

Judgment: Not compliant

Regulation 27: Infection control

The infection prevention and control processes in the centre required improvement to ensure compliance with the national standards for infection prevention and control in community health services and other national guidance. This was evidenced by:

- The centre was not a clean environment as several areas were visibly dirty. This is a repeated finding from the previous inspection.
- The centre was not well maintained and this meant that some areas were

difficult to keep clean and as a result dust and debris were visible. For example:
    - The floor linings in the centre have holes and cracks, and as a result, dust and debris have accumulated in these holes.
    - High-touch surfaces like handrails were damaged at some locations and did not support effective disinfection of the surfaces.
- A bathroom in the centre was dirty and foul smelling.
- The arrangement to clean the clinical equipment was not effective. For instance:
- Several specialised chairs stored in the bedroom were visibly dirty.
- Soft furnishings of several assistive chairs were ripped and did not support effective cleaning.
- Glucometers were shared between different residents. As a result there was a risk of transmission of blood borne pathogens to the residents.
- The centre's laundry process did not support infection prevention and control in the centre. For instance:
    - There was no clear separation in the laundry between clean and dirty clothes, and the inspector observed that an open laundry trolley with soiled clothes was kept close to clean clothes. This posed a risk of contamination of clean clothes.
    - In addition, the cloth drier in the laundry was found to be damaged and was not timely repaired. As a result, the laundry process in the centre did not ensure effective cleaning of contaminated clothes.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had not completed all of the fire safety works that were required in the designated centre in line with their own action plan provided to the Chief Inspector following the fire safety risk assessment that was completed in July 2021.

While there were weekly and daily checks carried out in the centre as part of the centre's fire precaution, the inspector noted they were not effective. For instance:

- The automatic door closures of some of the fire doors were not working. As a result, the sub-compartment fire doors of some rooms did not ensure a tight seal when they were closed.
- The fire drill records kept were not sufficiently detailed to evaluate the effectiveness of the fire drill. The emergency fire drill was not simulated and had not included all the residents in the centre's largest compartment. In addition, the drill record did not include the dependencies and level of assistance of residents occupying the centre's largest compartment. The centre's largest fire compartment can occupy ten residents.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had not ensured that a medicinal product which was out of date and medicines that had been dispensed to residents but were no longer required by those residents were not segregated from other medicinal products and disposed of in accordance with the national legislation. The staff removed the medicines from the drug trolley during the inspection and assured the inspector that they made arrangements to dispose of the outdated and unused medication safely.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While all the residents in the centre had a care plan in place, the inspector noted that the provider had not sufficiently reviewed residents care plan to meet their current needs. For example:

For example:

- Some residents who were assessed as requiring mobility assistance did not have this information accurately detailed in their care plan.
- Several residents did not have an appropriate, meaningful activities care plan to support their care needs in line with their preferences and capacities.

Judgment: Substantially compliant

Regulation 6: Health care

Some residents in the centre did not receive a high standard of evidence-based care. For example:

- Arrangements in the centre were insufficient for a resident to receive timely medical attention on the inspection day. In addition, the inspector noted that a resident was not provided with appropriate nursing care. The inspector received satisfactory assurance regarding the resident's care following the inspection.
- Even though a resident's wounds were dressed at regular intervals, wound assessments were not carried out to evaluate the effectiveness of

intervention and the progress of wound healing.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The care practices in the centre to manage responsive behaviours required improvement to ensure that the measures taken are least restrictive and the restrictive practices in the centre were managed in line with the national guidelines.

- Door locks were installed in corridors to manage the residents with responsive behaviours, who moved around the centre. As a result the residents were congregated in the interior of the building and did not have access to the other areas of the centre.
- The day rooms in the centre were unsupervised and falls alarm bells were attached to residents' chair to alert staff when a resident moves. The measures did not prevent the residents from falling as the staff were not available near the day room to provide timely assistance for the residents.
- The use of door locks and falls alarm were not identified as restraints and were not entered into the centres' restraint register.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had not taken reasonable measures to protect residents from abuse. For example:

- an incident related to an allegation of abuse was not investigated,
- an appropriate safeguarding plan was not in place for one resident who was vulnerable as a result of their responsive behaviours.

Judgment: Not compliant

Regulation 9: Residents' rights

The residents were not provided with opportunities to participate in activities in accordance with their interests and capacities. For example:

- There was no activity programme scheduled for the residents in the centre
- Staff were not allocated to provide meaningful activities for residents in

accordance with their preferences and capacities.

The provider had not made necessary arrangements for the residents to exercise choice in accessing the outdoor area of the centre independently. For example, the inspector noted that the residents' access to the corridors, reception and dining rooms facing the outdoor of the building was overly restricted, and the resident had to seek staff assistance in gaining access to the areas.

In addition, the registered provider had not provided appropriate facilities for the residents to enjoy their favourite television programs and access to the Internet in the centre.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ramelton Community Hospital OSV-0000615

Inspection ID: MON-0035201

Date of inspection: 04/08/2022

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:
It was confirmed to the inspector on day of inspection that two planned fire training sessions were cancelled as the Hospital had a Covid-19 outbreak. Further training dates were scheduled as follows:-26.07.2022, 22.09.2022, 04.10.2022 and 22.11.2022. This will ensure that all staff will have attended fire training by year end. Staff who are due/overdue will be prioritized for training. Completed by 31.12.2022.

The Nurse in Charge confirms that the resident referenced by the Inspector had received personal care on the morning of inspection and had further nursing interventions completed later that morning. A call was logged with his G.P. who attended the Hospital on 05.09.2022 and commenced the resident on Chloromycetin eye drops for conjunctivitis. The resident had also been assessed by his G.P. on 02.08.2022 for an irritating skin condition which affected his face and body. The G.P. prescribed E45 cream and Aveeno body wash and shampoo which have proved to be a very effective treatment.

Strengthening of Training and Supervision
The Management Team within the designated centre have put in place ongoing spot-checks, Management walkabout and records of audits are kept by the DON and CNMII

Management Walkabouts:
The DON/CNM 2 are conducting ongoing spot checks at mealtimes to ensure staff are adhering to our person centered approach when assisting residents at mealtimes. They have found resident's dignity is being maintained and mealtimes are conducted in a friendly and warm environment. Records of these Audits are maintained.

Cleaning within the Centre:

The Cleaning within the designated centre has improved with the centre now being cleaned to a high standard , weekly spot-checks by the management team of cleaning schedules are ongoing and recorded.

A MEG Environmental Audit was completed on 14/09/2022 by a Clinical Nurse Specialist, CHO1 Community Infection Prevention & Control Team, with the Unit achieving an overall score 88.2%. A Quality Improvement Plan is in place and work has commenced to address all issues of concern. A phased plan of works has been agreed to complete fire works, painting works and new flooring.

Phasing for the remainder of the works is programmed as follows:
Phase 1: commenced on 1.09.2022, due for completion on 14.10.2022
Phase 2: due to commence on 17.10.2022, due for completion on 25.11.2022
Phase 3: due to commence on 28.11.2022, due for completion on 20.01.2023
Phase 4: due to commence on 23.01.2023, due for completion on 10.03.2023
Phase 5: due to commence on 13.03.2023, due for completion on 14.04.2023

In consultation with Maintenance Department and IPC all floor coverings which are cracked/damaged are being replaced. This work will commence once the fireworks have been completed with an expected completion date by 31.10.2023.

Regulation 23: Governance and management	Not Compliant

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

Chemicals: All chemicals used within the designated centre are recorded on the Risk Register with Safety Data Sheets to advise on Handling, Storage, and emergency measures to take in case of an accident.
2 lockable Hazardous substance Cabinets have been requisitioned from stores and will be fitted when received . All staff are aware of the need to identify and Health and Safety concerns to the Health and Safety Representative within the Centre or to one of the Management Team. On the 5th October 2022 the DON, CNMII and the Health and Safety Rep received training on Risk Assessment delivered by the HSE Health and Safety Officer CHO1 .

Staff have been advised of the need to ensure that doors to store rooms, with keypad access, which contain harmful chemicals are kept locked at all times. The CNM2 will continue to monitor. Completed by 22.08.2022.

Care Plan Audits

Care Plan Audits will be completed more robustly to ensure that all issues are identified and an action plan completed as required. Advice from Practice Development Co Ordinator will be sought as required. Two link nurses have completed refresher training on the Care Notes system 08.09.2022 and will liaise with all nursing staff in relation to ongoing care plan audits. Further training has been provided to 5 nurses on 28.09.2022 by Personal Development Co Ordinator. CNM 2 has received further care plan audit training on 05.10.2022. The CNM 2 will continue to monitor. Completed by 05.10.2022.

The importance of prompt action and reporting of any issues with fire doors has been emphasized in meetings with the General Operative. The PIC is to be informed immediately of all issues identified. External Fire Specialists have completed an inspection of all fire doors within the unit including the automatic door-closure devices, which are now closing properly. Completed by 15.09.2022.

All incidents which are recorded on the National Incident Management System (NIMS) are audited monthly by the DON. Incidents are broken down into categories- date and time of incident, where incident occurred and type of incident. Investigation of incidents, learning from incidents and action plans are recorded. Audits of incidents are on the agenda at team meetings and at Quality, Risk and Safety Group Meetings. Completed by 30.08.2022.

Staff Supervision of Residents in Day Rooms: This is the responsibility of each nurse in charge on all shifts to monitor and ensure that ongoing supervision in Day Rooms is maintained. Completed by 08.08.2022.

An Activities Plan has been drawn up in consultation with residents. A portfolio of residents life stories, interests and favourite pastimes is compiled in a booklet called "This is Me" for all long term care residents. Social Care Plans are in place and have been reviewed and updated. These plans will be reviewed regularity by the CNM2 Completed by 30.08.2022.

Residents are asked daily if they wish to dine in the dining room, some prefer to have their meals where they are seated and this is facilitated. Menu choices are now printed off daily and residents who do not wish to dine in the dining room are aware of the choices available each day. Appropriate supervision is provided by staff during all mealtimes. Completed by 05.08.2022.

Chef 1 consults with residents around food preferences, likes and dislikes and works on menus to suit all residents as much as practicable. Chef 1 has attended the October focus group meeting with residents, and residents have been given an opportunity to put forward ideas/suggestions around menus, mealtimes and where they prefer to dine. Completed by 07.10.2022.

In relation to the allocation of single bedrooms, a full assessment based on individual

need and dependency is carried out and room allocation within the Centre is finalised according to the assessment. Full communication takes place with the resident throughout. Completed and ongoing by 18.8.2022

Staff are completing daily activities with residents including: -foot spa and massage, hand massage and nail care, bingo, afternoon tea parties, and quizzes. Several residents attended the Ramelton vintage show and soap box derby in July. There is flower planting, music sessions, games, newspaper reading and discussion ongoing. There is weekly Mass which Residents really enjoy. Staff assist residents to make WhatsApp calls to family. Residents are encouraged to go out with their families and any assistance required is fully facilitated. Focus Groups are completed by a staff member on a monthly basis where residents can raise any concerns/issues they may have and any issues are addressed by the CNM2/DON. Completed and ongoing on 22.08.2022.

Satisfaction Surveys are completed monthly with residents.

A Planned programme of decoration for the entire Designated Centre is in process. All bedrooms and corridors will be painted as fire works are completed (see phases below). Residents will be consulted around choosing a preferred colour for their bedrooms. Completed by 14.04.2023.

Phasing for the remainder of the works is programmed as follows:
Phase 1: commenced on 1.09.2022, due for completion on 14.10.2022
Phase 2: due to commence on 17.10.2022, due for completion on 25.11.2022
Phase 3: due to commence on 28.11.2022, due for completion on 20.01.2023
Phase 4: due to commence on 23.01.2023, due for completion on 10.03.2023
Phase 5: due to commence on 13.03.2023, due for completion on 14.04.2023

In consultation with Maintenance and IPC all floor coverings which are cracked/damaged are being replaced. This work will commence once the fire works have been completed with an expected completion date by 31.10.2023.

Courtyard Dayroom painted on 12.09.2022.

Reception area and corridor C2 painted on 15.09.2022.

Refurbishment works on Treatment Room, Clean Utility Room and Hairdressers Room are commencing week beginning Monday 19th September 2022, to include new storage units, new flooring and painting. Completed by 30.10.2022.

New clinical sinks will be installed on Corridor C4 and C6 and Corridor C7. This work will be completed in conjunction with new flooring works. Completed by 31.10.2023.

Residents who are at risk of developing pressure ulcers are re positioned at frequent intervals as documented in their care plans.
Training in Tissue Viability took place within the designated centre on Monday 3rd October which was attended by CNM 2, S/Ns, HCAs and MTA staff. This training focused on Pressure Ulcer prevention and Skin Care Bundle Documentation. We now have 2 staff nurses who will act as link nurses for Tissue Viability Care. These nurses will be given the opportunity to complete stand- alone wound care module under the guidance of TVN Specialist. We also have nominated 1 HCA and 1 MTA who will be champions around Aids and Appliances for Pressure area care. They will complete weekly checks of equipment used and report any issues to CNM 2. Residents who are at risk of developing pressure ulcers are repositioned at frequent intervals in line with the prescribed care in their care plans. Skin care bundles are completed for all residents at risk of developing pressure sores, with the time frames for repositioning of residents documented by the S/N responsible for that resident. This will be closely monitored by the CNM2. Completed and ongoing by 03.10.2022.

Time is allocated for Physiotherapy sessions for residents who require this service. For some residents who require short walks to assist with their mobility the Physiotherapist undertakes walking exercises within their own environment. To ensure the residents privacy is maintained at all times the physiotherapist will assess if the resident can be mobilized within their own bedroom and if not they will assist the resident to the Physiotherapy Department where they will receive the required exercise. The Physiotherapist discusses the plan of care with each resident and consults with the resident as when and where their exercises will be take place. The nursing staff ensures the resident is happy to continue prior to any intervention taking place. Completed and ongoing on 20.09.2022.

Annual Review:
The Annual Review was completed with the new Provider Nominee on 02.09.2022.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Notification of incidents to HIQA will be completed within the required timeframe. Completed 05.08.2022

Key pads on doors will be added to the restraint register and submitted as part of quarterly notifications on the use of restraints in the Designated Centre. Completed by 22/08/2022. With regards to the Physiotherapy Department area within the Hospital, HSE Estates are assessing various options to physically separate the Physiotherapy Department /waiting area/entrance from the hospital main entrance. This work will involve revisions to mechanical and electrical services, revised fire escape strategy, relocation of an existing office and reduction of usable space in the entrance area and

possible issues with ramps to the additional entrance. A drawing showing the preferred options will be issued to HIQA for discussion, once the options have been fully assessed. The Physiotherapy Department currently advise Out Patient Clients to wait in their car until called by the Physiotherapist who will assist them into the Physiotherapy Department. Maintenance have been contacted and a call bell/intercom system for the Reception area, Ward area and Physiotherapy area will be installed as an interim arrangement and until the other options above have been explored. This will be completed by the 31/10/22

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A record of complaints is available in the Centre and was viewed by the Inspector on the day of inspection. A more robust investigation, outcome of complaint, any learning identified and an action plan for all complaints will be maintained. Advice will be sought from the Consumer Services Manager as required. Completed and ongoing by 20.09.2022.

With assistance from Practice Development a revised policy on the Management of Service User Feedback, Comments, Compliments and Complaints was issued on 05.09.2022 from which a new complaints form has been identified and is in use within the Designated Centre. Information on this policy is made available to all residents on admission.
Completed and ongoing by 10.10.2022.

The CNM2 will now investigate all complaints and the DON will oversee and sign off that the complaint has been dealt with correctly and within the required time frames in consultation with Consumer Services where required. Completed and ongoing 05.09.2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Works including new Marmoleum Flooring and Painting have been completed in the wheelchair storeroom which has provided more space for storage of equipment. The weekly cleaning schedule has been updated and checked. Completed and ongoing by 30.08.2022.

The Sara Steady hoist is used by one resident to transfer from wheelchair onto his seat in the Courtyard Dayroom. An alternative storage area has been sourced for assistive equipment when not in use. Completed by 10.08.2022.

Residents are assessed prior to admission to single bedrooms. Based on the individual assessed needs and dependency, room allocation within the centre is finalized according to the assessment. Full communication takes place with the resident throughout. Completed and ongoing by 18.8.2022

A plan of decoration is in process. All bedrooms and corridors will be painted as the fireworks are finished. Completed by 14.04.2023.

A walkabout in the unit was completed by the IPC Manager on 07.09.2022, who assessed flooring, storage units and the need for extra clinical sinks. New flooring is required for all areas which were identified as being damaged. Extra clinical sinks will be provided on Corridor C4 which has five single bedrooms and Corridor C7 which has ten single bedrooms and another on Corridor C6. It is expected that this work will be Completed by 31.10.2023.

Reception area and Corridor C2 painted on 15.09.2022.
Courtyard Dayroom painted on 12/09/2022.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Meetings held with housekeeping staff. A more robust cleaning processes to be initiated on a daily basis and the importance of updating cleaning schedules has been emphasized to all Staff. This will be closely monitored by the CNM2. Completed and ongoing by 30.08.2022.

All residents now have their own personal Glucometer. Completed by 15.08.2022.

A walkabout in the unit was completed by the IPC Manager on 07.09.2022, who assessed flooring, storage units and the need for extra clinical sinks. New flooring is required for all areas which were identified as being damaged. Completed by 31.10.2023.

Laundry services reviewed and laundry is now outsourced on a permanent basis. Completed by 12.09.2022.

A MEG Environmental Audit completed on 14.09.2022 by Clinical Nurse Specialist, CHO1 Infection Prevention & Control Community Team – overall score 88.2%. A Quality

Improvement Plan is in place and work has commenced to address all issues identified. IPC will maintain a visible presence, completing spot checks and monitoring housekeeping practices going forward.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Automatic door closures checked by External Fire Specialist and all working effectively. Completed by 15.09.2022.

All Red Fire Risks were completed prior to 9th February, 2022. Email confirming completion of red fire risks sent to inspector on 24.02.2022.The risk associated with the ceiling falling short of 30 minutes fire resistance was considered as a medium risk and not a high risk. These remedial works commenced on 1st September 2022 and Phase 1 is 50-60% completed to date. It is estimated that all works will be completed by 14th April 2023 and all outstanding works will be completed during the course of Phases 1 - 5.

Phasing for the remainder of the works is programmed as follows:
Phase 1: commenced on 1.09.2022, due for completion on 14.10.2022
Phase 2: due to commence on 17.10.2022, due for completion on 25.11.2022
Phase 3: due to commence on 28.11.2022, due for completion on 20.01.2023
Phase 4: due to commence on 23.01.2023, due for completion on 10.03.2023
Phase 5: due to commence on 13.03.2023, due for completion on 14.04.2023

Amber Risks-new over boarding on all ceilings commenced on 01.09.2022. Completed by 14.04.2023.

Personal Evacuation Plans are now stored beside fire panel on Corridor C6 as requested by the Inspector and a copy of the PEEPS is also available at Reception Office. Completed by 15.08.2022.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Hospital has a service level agreement with a local Pharmacy, which details the system in place to deal with disposal of unused/expired medications. CNM2 will monitor

closely. Completed and ongoing on 10.08.2022.

Nursing Staff have read and signed off Schedule 5 Policies on Management and Administration of Medicines to include Controlled Medications and Ordering, Receipt, Storage and Disposal of Medications. Completed by 30.08.2022.

Nursing Staff complete Medication Management Module on HSEland yearly.

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:
Practice Development Co-Ordinator will be on site on 28.09.2022 to provide training/guidance to nursing staff on effective care planning. Completed by 30.09.2022. Further training will be available in the Centre for Nursing and Midwifery and Education in the Autumn, dates not available as yet.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Timely health care is provided to all residents within the hospital. Follow up actions for one resident following inspection were forwarded to the inspector by the CNM2 on 08.08.2022.
All wound assessments are now updated to reflect the effectiveness of intervention and the progress of wound healing. Nursing staff reminded at team meetings/handover re the importance of ensuring all documentation is updated when any intervention takes place. This will be monitored by the CNM2. Completed by 15.08.2022

A Tissue Viability Specialist has been requested to review practice within the Unit and will be in attendance on 28.09.2022.

All Nursing Staff have read and signed policy on Wound Care Management

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:
Falls prevention aids are recorded on the Residential Restraint Register. This will now be submitted as part of quarterly notifications. Completed by 31.08.2022

Keypads were added to doors within the Designated Centre as instructed by a previous HIQA inspector. Keypads on doors will be added to the Restraint Register and submitted as part of quarterly notifications. Completed by 31.08.2022.

ABC Charts are completed by staff when a resident displays behaviour that is challenging.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In relation to the incident of the allegation of abuse which was not investigated. The PIC followed up directly with Safeguarding and submitted a Preliminary Screening to Safeguarding. The Safeguarding Team CHO1 indicated that the incident was not a safeguarding incident. Same closed on 08.09.2022.

100% of staff have undertaken Safeguarding Training on HSELand. A visit to the Unit from the CHO1 Safeguarding Team has been confirmed, who will provide face to face training for staff on Safeguarding awareness. Completed by 15.12.2022

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Support Staff provide meaningful activities to residents. A weekly programme of activities is planned in consultation with residents and is available in both Day Rooms for residents information. Completed by 30.08.2022.

Social Care Plans are in place and updated regularly. Completed by 30.08.2022.

Access to the Dining Room is through the link corridor for any resident who wishes to go to the Dining Room other than at mealtimes. Completed by 08.08.2022.

Residents can freely access the Reception area via link corridor. Regarding the Physiotherapy Department area within the Hospital, HSE estates are assessing various options to physically separate the Physio waiting area/entrance from the Hospital main entrance. This work will involve revisions to mechanical and electrical services, revised fire escape strategy, relocation of an existing office and reduction of usable space in the entrance area and possible issues with ramps to the additional entrance. A drawing showing the preferred options will be issued to HIQA for discussion, once the options have been fully assessed. The Physiotherapy Department currently advise Out Patient Clients to wait in their car until called by the Physiotherapist who will assist them into the Physiotherapy Department. Maintenance have been contacted and a call bell/intercom system for the Reception area, Ward area and Physiotherapy area will be installed as an interim arrangement and until the other options above have been explored. This will be completed by the 31/10/22

Easy access to the outside courtyard is through double doors on the link corridor. Residents sit there on pleasant summer days and go for short walks within the Courtyard. Residents also attend flower planting and other activities in the courtyard area weather permitting.

Several residents have requested SKY TV be made available within the Designated Centre, this will be addressed on completion of ongoing fireworks. Completed by 14.04.2023.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	22/08/2022
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	22/08/2022
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	14/04/2023
Regulation 23(a)	The registered	Substantially	Yellow	22/08/2022

	provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Compliant		
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	15/09/2022
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	02/09/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Not Compliant	Orange	30/08/2022

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	14/04/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	15/09/2022
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger	Not Compliant	Orange	10/08/2022

	to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
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.	Not Compliant	Orange	05/08/2022
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	31/08/2022
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint,	Not Compliant	Orange	20/09/2022

	the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Substantially Compliant	Yellow	08/09/2022
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Not Compliant	Orange	05/09/2022
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in	Not Compliant	Orange	05/09/2022

	paragraph (1)(f).			
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	30/09/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	15/08/2022
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and	Substantially Compliant	Yellow	31/08/2022

	respond to that behaviour, in so far as possible, in a manner that is not restrictive.			
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	31/08/2022
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	08/09/2022
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/08/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/08/2022
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 Compliant	Orange	31/10/2022

	not interfere with the rights of other residents.			