Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	New Ross Community Hospital
Name of provider:	New Ross Community Hospital Company Limited by Guarantee
Address of centre:	Hospital Road, New Ross, Wexford
Type of inspection:	Unannounced
Date of inspection:	18 January 2024
Centre ID:	OSV-0000602
Fieldwork ID:	MON-0041978

About the designated centre

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

The centre occupies the ground floor of a two-storey facility built in the 1930s with residential capacity of 35 persons (both male and female) on the ground floor. It is located on the same grounds as the Health Centre, Day Care Centre and New Houghton Hospital. It provides 24 hour 7 day qualified nursing care for persons with the following care needs: long term/ residential care, short term, non-acute medical, respite, convalescence, palliative care, family emergencies and young chronically ill over eighteen years of age. There are 13 single rooms, eight of which are en suite and 11 twin rooms. Other rooms available included a day room, an activity room, quiet room, prayer room, kitchen, dining room, sluice rooms, a laundry, treatment room and offices. There was a secure garden area for residents use in addition to a secure courtyard. Some parking was available at the front of the building. There is also access to a shared car park on the grounds. According to their statement of purpose, the centre aims to provide an environment that residents can regard as a home from home. Committed and professional staff are focused on ensuring all residents are cared for in a safe, warm, secure and caring environment, based on the principles of home. Their objective is to provide a high quality of resident-centred care to all in accordance with evidence based best practice; to ensure residents live in a comfortable, clean and safe environment that promotes the health, rights and independence of the residents of the hospital.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	31

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 18 January 2024	09:30hrs to 19:20hrs	Aisling Coffey	Lead
Thursday 18 January 2024	09:30hrs to 19:20hrs	John Greaney	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they liked living in the centre. The residents spoken with were highly complimentary of the staff and the care they received. One resident told the inspector the centre was "like a hotel" and "everyone is lovely". Another resident informed inspectors that "I love it here" and that the staff would "do anything for you". Staff were aware of residents' needs and were striving to provide good quality care. Inspectors observed warm, kind, dignified and respectful interactions with residents and their visitors throughout the day by staff and management.

Inspectors arrived at the centre in the morning to conduct an unannounced inspection. Following an introductory meeting with the person in charge, the inspectors were guided on a tour of the premises. During the day, the inspectors spoke with several residents and their families to gain insight into their experience in New Ross Community Hospital. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

New Ross Community Hospital is a two-storey building on a healthcare campus that accommodates several health and social care services in New Ross. The centre is close to shops, restaurants, and public transport services. The main entrance to the designated centre was accessed through an open porch leading to a small lobby area. The door to the lobby area was locked, requiring keypad access. The centre was in the process of being redecorated on the day of inspection, although painting was not occurring on that day. The centre had an outbreak of Covid-19 on the day of the inspection. The outbreak had affected two residents who no longer required isolation. Signage in the lobby area informed visitors of the outbreak, and masks were also available for those who chose to wear one.

The centre is registered to accommodate 35 residents and provides long-term residential care, respite residential care, convalescence care and palliative care. There were 31 residents in the centre on the morning of the inspection, with four vacancies. The centre provides resident accommodation on the ground floor, while the first floor accommodates a staff canteen, two store rooms, two offices and two staff changing areas for the centre. The remaining space on the first floor is office accommodation used by another service. While the building was constructed in the 1930s, it was refurbished and extended in 2016 to provide eight single spacious ensuite bedrooms, a multipurpose room for activities, a nurses station, an office and an internal courtyard. Resident accommodation in the older part of the building comprised a further 11 twin bedrooms and five single rooms. These bedrooms did not have ensuite facilities, and these residents used the centre's communal shower, bath and toilet facilities. Bedroom accommodation was homely and comfortable, personalised with photographs, pictures, art and furniture belonging to the residents. Each bedroom had a bedside locker, locked storage, a wardrobe, seating and television facilities. Each resident had an information folder in their bedroom containing the centre's information guide, statement of purpose, details of advocacy

services, the centre's complaints procedure, activities schedule and menus. Some residents did not have call bell access and the person in charge undertook to rectify this matter. Communal shower, bathing and toilet facilities comprised six shared single toilets and five shared shower rooms, two of which contained a further toilet and two that were registered as having a bath. Of the two shower rooms registered as having a bath, one shower room had a broken bath that could not be used by residents, while in the other shower room the bath had been removed and this room was being used for storage. The shower facilities were in very poor condition, requiring maintenance. These matters will be discussed under Regulation 17: Premises.

The centre's design and layout supported residents' free movement, with wide corridors, sufficient handrails, and armchair seating within communal areas. Communal space consisted of a dayroom/sitting room, a dining room, an activity room, a bay window seating area and a reflection room. The reflection room was not available to residents on the inspection day as inspectors observed it was in the process of redecoration, with painting materials in the room. Residents also had unrestricted access to two outdoor areas: a small courtyard directly opposite the main entrance and a very pleasant covered seating area overlooking a spacious, well-maintained new residents garden. The courtyard and covered seating areas had sheltered accommodation for residents who chose to smoke. The centre was pleasantly decorated with photographs of resident activities and birthday celebrations.

Residents were up and dressed in their preferred attire and appeared well cared for. Residents freely mobilised around the centre, watching television, reading the newspaper, and chatting with other residents and staff. A designated activities coordinator was working within the centre. Residents spoke positively about the activities they enjoyed in the centre, including bingo and exercises. Inspectors observed multiple activities throughout the day, including mini golf, bingo and a prayer service. Inspectors saw the activity rota on display and noted a range of interesting and engaging activities taking place seven days per week.

Residents were complimentary of the food on offer. Menus were available in each resident's bedroom to inform their choice of meals. There were refreshments available for residents throughout the day. Inspectors observed mealtimes in the dining room as a sociable and relaxed experience, with residents chatting together and staff providing discreet and respectful assistance where required. Some residents were facilitated to eat in their bedrooms, aligned with their preferences. The inspectors observed that one resident was asleep in their bedroom at lunchtime and had not eaten lunch. The inspectors did not observe any staff member overseeing residents having their lunch in areas other than the dining room to ensure these residents received appropriate assistance. Within the dining room, inspectors observed that one resident prescribed a modified consistency diet was served an inappropriate diet, which posed a safety risk. This was immediately addressed during the inspection. Additionally, inspectors found that improvements were required in the communication systems between nursing and catering staff to ensure each resident received food and hydration in line with their assessed dietary

needs. These areas for improvement are discussed in more detail under Regulation 18: Food and nutrition.

Discussions with residents confirmed they felt very happy and safe living in the centre. Residents spoke positively about the kind and helpful staff that cared for them. Family members who spoke with inspectors were pleased with the care received by their loved ones, as well as the kindness and respect shown to residents by staff and management. Inspectors observed staff being respectful, caring and attentive to residents' needs.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

While several aspects of the service had improved since the previous inspection, the management and oversight systems were not sufficiently robust to ensure that the service provided to residents was safe, appropriate, consistent, and effectively monitored.

This was an unannounced inspection to monitor the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended) and to review the registered provider's compliance plan arising from the previous inspection. The inspection also informed the provider's application to renew registration. While the provider had progressed with some aspects of the compliance plan following the last inspection in April 2023, this inspection demonstrated deficits in the overall governance and management of the service. As discussed throughout the report, improvements continued to be required to comply with several regulations. In particular, repeated non-compliances were found under Regulation 27: Infection control and Regulation 17: Premises. The inspectors followed up on unsolicited information that had been submitted to the Office of the Chief Inspector since the previous inspection. This unsolicited information was related to staffing and notification of incidents.

The registered provider is New Ross Community Hospital Limited by Guarantee. A board of directors provided oversight of the centre. The board of directors consisted of five directors, including the chairperson who represented the provider for regulatory matters. Communication systems were in place between the board of directors and the person in charge. The person in charge reported to the chairperson and provided a report at monthly board meetings. Within the centre, the person in charge held staff meetings where aspects of quality service delivery, such as health and safety and infection prevention and control were discussed.

The person in charge worked full-time in the centre and commenced in the position in January 2023. She had the required experience and qualifications to fulfil the regulatory requirements of the role. The person in charge was supported by an assistant director of nursing, registered nurses, healthcare assistants, catering, household, administration, maintenance and activities staff. Residents' laundry is outsourced to an external company with collection and delivery three days per week. A review of the rosters identified adequate numbers and skill mix of staff on duty to meet the needs of the residents during the day. On the inspection day, two nurses were on duty from 8:00am to 8:00pm. There were three healthcare assistants on duty from 8:00am until 8:00pm, two healthcare assistants from 8:00am until 2:00pm and a further two healthcare assistants from 5:00pm until 8:00pm. A review of the night time staffing hours was required, which is discussed in more detail under Regulation 15: Staffing.

While the observations of inspectors indicated adequate numbers and skill mix of staff, the supervision arrangements needed to be enhanced to ensure care was delivered in accordance with residents' assessed needs, particularly at mealtimes. Inspectors were provided with a training matrix. This identified that staff had access to mandatory training, including fire training, safeguarding, infection prevention and control and managing behaviour that is challenging. Good compliance levels were identified in all of these areas. However, it was identified that staff training included in the training matrix may not be centre-specific, may not be appropriate to a care setting or may not be provided by a person with the necessary qualifications. These issues are outlined further under Regulation 16: Training and staff development. Staff files were reviewed. All staff files contained Garda Siochana (police) vetting and identification. However, the personnel files did not contain all of the documentation required to ensure safe and effective recruitment practices which will be discussed under Regulation 21: Records.

There were systems in place to monitor the quality and safety of care delivered to residents through an audit schedule covering areas such as medication management, infection prevention and control, restrictive practice, wound care, falls management, care planning and nutrition. While the programme of audits was comprehensive, the auditing system needed to be more effective in identifying deficits and risks in the service and driving quality improvement. There were disparities between the high levels of compliance reported in the centre's audits and the inspectors' findings in areas such as infection prevention and control for example. While other audits, in nutrition for example, did not have time-bound action plans or a system to share the learning from the audit. Similarly, while a comprehensive annual review of the quality and safety of care delivered to residents was completed for 2023, the review found that the centre did not require improvement in 34 out of 35 standards examined, and accordingly, there was no quality improvement plan.

While the centre had a system for incident recording, inspectors found that specific incidents, such as falls, were not being recorded as incidents in line with the centre's policies and Schedule 3 requirements. This meant that trending to analyse these incidents to reduce risk and promote safety and quality improvement was not occurring. This will be discussed under Regulation 21: Records. Additionally, the

Chief Inspector of Social Services had not been notified of relevant prescribed incidents within the required time frames, which is outlined under Regulation 31: Notification of incidents.

The registered provider had insurance in place to cover injury to residents. There was a directory of residents living in the centre. Volunteers had roles and responsibilities in writing, received supervision, and had Garda Siochana (police) vetting disclosure on file.

The centre's complaints procedure was contained within the residents' guide and was displayed within the centre's reception and outside the director of nursing's office. Advertisements for advocacy services to support residents in making a complaint were displayed in the centre and in the resident's information guide, available in each bedroom. The centre had a nominated complaints officer and a review officer. There were written records outlining how complaints were managed in the centre. Residents and families said they could raise a complaint with any staff member and were confident in doing so if necessary. Staff were also knowledgeable about the centre's complaints procedure. Notwithstanding this good practice, some improvements were required to comply fully with the regulation discussed under Regulation 34.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to renew the designated centre's registration in accordance with the requirements in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015. At the time of inspection, this application was being reviewed.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was recently appointed to the role. She has the required experience and qualifications to fulfil the regulatory requirements of the role.

Judgment: Compliant

Regulation 15: Staffing

A review was required of night time staffing levels. A roster review identified one nurse and two healthcare assistants on duty from 8:00pm to 8:00am. Staff

confirmed that the nurse administered medications after commencing duty, which could take approximately two and a half hours. One of the healthcare assistants was assigned to serve tea and snacks to residents, while the other healthcare assistant was responsible for answering call bells and meeting the care needs of residents. With 22 residents having high to maximum dependency care needs, requiring the assistance of two staff, this meant that the nurse would have to interrupt the medication round, or the healthcare assistant would have to interrupt the tea round to support these residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Action was required in relation to staff training to ensure that staff had the necessary skills to perform their roles. For example:

- A review of a staff file identified that manual handling training had been completed before commencing employment in the centre. This training did not include people-moving and handling skills, which is a requirement for employment in a care setting. The training matrix incorrectly identified that this person had up-to-date manual handling training.
- The training matrix identified that a member of staff had up-to-date fire safety training; however, this was provided in another centre and was not specific to this centre.
- Assurances were required that mandatory fire safety training was accurately reflected in the training matrix. A staff member received a lecture on fire safety provided as part of induction, which was recorded on the training matrix as full mandatory fire safety training.

Action was required in relation to staff supervision to ensure that residents received assistance with their meals when required. For example:

- Inspectors noted that one of the residents having lunch in their bedroom had fallen asleep with no lunch eaten. The tray remained there for some time and there was no evidence that staff were assigned to ensure that residents requiring assistance were provided with that assistance.
- The inspectors were informed that this same resident's food intake records indicated they had eaten all their lunch, which was not the case.

Staff supervision also needed to be strengthened with respect to household and cleaning duties. There were cleaning schedules in place that had been signed off as completed, such as cleaning of rooms or equipment. However, inspectors noted that two rooms undergoing redecoration were visibly unclean despite signed checklists that the rooms had been thoroughly cleaned the day before the inspection.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was up to date and was available for the inspectors to review. The directory contained all of the information as required under Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

A review of four personnel files found evidence of the staff member's identity and Garda Síochána (police) vetting disclosures. However, the personnel files did not contain all of the documentation required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) to ensure safe and effective recruitment practices. For example:

- None of the four personnel files contained full employment histories.
- While the files contained written references, it was unclear if one of those references was from the most recent employer, as required by regulation, as the reference template used by the centre did not identify the role of the referee, the capacity in which the referee knew the staff member, the length of time the referee knew the staff member, in what capacity the referee was providing a reference and the the name of the company the referee was currently employed with.
- There was no evidence of professional registration for 2024 for three nurses working in the centre.

A record of falls and treatment provided to a resident was not documented in line with the centre's own falls policy and as required by Schedule 3 (4)(l) of the regulations.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had insurance in place which covered injury to residents and loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

Management systems required strengthening to ensure the service provided was safe, appropriate, consistent, and effectively monitored as evidenced by the findings below.

Auditing processes needed to be more robust in identifying risk and driving quality improvement.

- With respect to identifying risk, there were disparities between the full levels of compliance reported in the centre's audits and inspectors' findings, for example, infection control, fire safety, access to call bell and medication management.
- In terms of driving quality improvement, an audit of nutrition identified residents at risk of malnutrition, but there was no time-bound action plan identifying what measures were taken and by whom in response to these findings.

The oversight and maintenance of incident reporting and recording needed to be more robust, as evidenced by inspectors' findings that:

- Statutory notifications to the Chief Inspector of Social Services were not submitted within the required time frames.
- Gaps were identified in the recording of falls and treatment provided to a resident, meaning this information could not be used to trend the falls, analyse causal or contributing factors, reduce risk and improve the quality of service for residents.

The oversight of staff practice needed to be more robust, as evidenced by the inspectors' findings that:

- Action was required concerning staff supervision to ensure that residents received assistance with their meals when required.
- Staff supervision also needed to be strengthened with respect to household and cleaning duties.

Management systems required strengthening to ensure that the service provided was effectively monitored:

- Fire safety management systems to protect residents in the event of fire were not adequate.
- Areas of the premises required maintenance and repair to be fully compliant with Schedule 6 requirements
- Action was required to ensure robust oversight of resident nutritional needs.

Judgment: Not compliant

Regulation 3: Statement of purpose

Some improvements were required to the statement of purpose to ensure that it complied with Schedule 1 of the regulations. For example, it did not contain:

- Arrangements in place to explain, review and discuss the resident's contract of care.
- An accurate description of the updated complaints regulation, including the time frames for providing a written response to the complainant.
- Details of pension agent procedures and arrangements for safeguarding residents' finances onsite.

Discrepancies were noted between the floor plans, statement of purpose and what was observed on inspection. For example;

- The shower and bathroom on the south wing did not have a bath in situ, and this room was not available to residents to use to shower as it was being used to store six wheelchairs, three shower chairs, laundry skips, a hoist and an electric wheelchair.
- Storeroom 6 on the first floor is registered as a resource for the designated centre on the floor plans and statement of purpose. Inspectors noted resident records in this store room that they wished to review. The person in charge confirmed that this room was not used by the centre but by the other service provider.
- A nurses' station was observed where treatment room 2 was positioned on the floor plans.

Judgment: Substantially compliant

Regulation 30: Volunteers

The person in charge ensured that individuals involved in the nursing home on a voluntary basis had their roles and responsibilities set out in writing. They received supervision and support, and provided a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of residents' nursing notes found that three incidents, one involving an injury requiring hospital treatment and two involving unexplained absences, were not notified to the Chief Inspector of Social Services. The person in charge submitted these notifications retrospectively after the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre's complaints processes needed to be updated to comply with Regulation 34. For example:

- The complaint's policy did not reference the role of the review offer and outline the relevant time frames for responding in writing to complaints.
- The nominated complaints officer had not completed training to support them in their role of managing complaints.
- The annual review of quality and safety did not reference the level of engagement with independent advocacy services with residents in 2023.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had prepared policies and procedures outlined in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People). With the exception of the complaints policy, all policies had been reviewed at intervals not exceeding three years as required by the regulations.

Judgment: Substantially compliant

Quality and safety

While inspectors observed kind and compassionate staff treating residents with dignity and respect, enhanced governance and oversight was required to improve the quality and safety of the service provided to residents, particularly concerning fire safety, infection control, premises, food and nutrition, medicines and pharmaceutical services, information for residents and temporary absence or discharge of residents.

Residents were supported in accessing medical and nursing services, including psychiatry of old age, palliative care services, the national screening programme and various allied health professionals. Three local general practitioners provided regular reviews of residents in the centre, and an out-of-hours GP service was also available if needed. Records confirmed a full range of other healthcare-related services were available for the residents in the centre. These included speech and language therapy, physiotherapy, occupational therapy, dietetic services, tissue viability and community mental health services. Chiropody, dental and optical services were also available. Residents with communication difficulties were supported to communicate their needs and preferences. There was evidence of residents with specialist communication requirements being facilitated to communicate through specialist means such as pictorial systems and assistive technology. Staff consulted with were also knowledgeable of residents' non-verbal cues. These cues were also documented in care plans viewed by the inspectors. Inspectors noted residents with sensory needs had been referred for specialist support to enable their communication and participation. Evidence of speech and language therapy, occupational therapy and optician interventions were seen on residents' files.

Inspectors reviewed records of residents transferred to and from acute hospital. Inspectors saw that where the resident was temporarily absent from a designated centre, in an acute hospital, relevant information about the resident was provided to the designated centre by the acute hospital to enable the safe transfer of care back to the designated centre. Upon residents' return to the centre, the staff ensured that all relevant information was obtained from the hospital and follow-up appointments and referrals were made. Additionally, records showed that discharges to the hospital were discussed, planned and agreed upon with the resident and, where appropriate, with their family. Notwithstanding this good practice inspectors were not assured that the transfer of residents from the centre was carried out in line with the requirements of the regulations as there were no records available of the information sent from the designated centre to the receiving hospital. This will be discussed under Regulation 25: Temporary absence or discharge of residents.

Each resident had a pharmacist available to them. The inspectors reviewed the practices and documentation relating to medication management in the centre. There were written policies relating to ordering, prescribing, storing and administering medicines to residents. There were procedures in place for the handling and disposing of unused and out-of-date medication. The temperature recordings of fridges for medicines that required refrigeration were monitored. Controlled drugs were stored securely within a locked cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice or three times daily, at the change of shift. Notwithstanding the above good practice improvements were required in relation to the secure storage of medicines and the procedure for transcribing medications which are discussed further under Regulation 29: Medicine and pharmaceutical services.

The centre had a pictorial information guide for residents in a folder in each resident's bedroom. The guide contained the majority of Regulation 20(2) requirements, such as information about the services and facilities provided in the

centre; however further additions were required which will be discussed under Regulation 20: Information for residents.

The premises of the designated centre were appropriate to the number of the residents. It had communal spaces for residents and their visitors to use. Some rooms were not being operated in accordance with the statement of purpose, which will be discussed under Regulation 3: Statement of purpose. Other areas required maintenance and repair to fully comply with Schedule 6 requirements. This will be discussed under Regulation 17: Premises. Inspectors observed that residents' bedrooms were personalised with items of importance to them, such as artwork, family photos and sentimental items from home. Residents had adequate space for storing their clothes, toiletries, and other belongings and displaying significant possessions. Each long-stay resident had access to lockable storage. While the centre's interior was generally clean on the inspection day, the environment and equipment management required improvement to minimise the risk of transmitting a healthcare-associated infection. This will be discussed under Regulation 27.

Systems were in place for monitoring fire safety. Fire extinguishers, the fire alarm, and emergency lighting had preventive maintenance conducted at recommended intervals. Staff spoken with were clear on what actions to take in the event the fire alarm was activated. Each resident had a completed personal emergency evacuation plan to guide staff. The centre had a designated fire warden, who had received fire warden training. There were records of this person providing lectures to staff and residents on fire safety. Annual fire training from a competent person took place while the fire warden inducted newly recruited staff in fire safety procedures. Notwithstanding this good practice, multiple gaps in the systems above were identified and improvements were required which will be discussed under Regulation 28: Fire precautions.

Residents were complimentary about the quality and quantity of food in the centre. Choice was offered to residents, and menus were available in every bedroom. Records confirmed that the catering staff had received food safety training. Notwithstanding this good practice, inspectors found that the improvements were required to ensure robust oversight of resident nutritional needs, which will be discussed under Regulation 18: Food and nutrition.

Residents could receive visitors in the centre, and visitors confirmed they were very welcome. Visitors and residents confirmed there were no restrictions on visiting. Residents had access to radio, television and newspapers. There were arrangements in place for residents to access advocacy services. Residents were supported to practice their religious faith. Roman Catholic services took place in the centre weekly. Inspectors were informed other religious beliefs would be supported as required, and all residents were currently catered for. Resident meetings were held regularly in the centre, providing opportunities to discuss different aspects of the service, including accommodation, maintenance, food, and activities. Residents had received a lecture on the Assisted Decision-Making Act and elder abuse. Residents also received regular fire safety lectures. Residents had been informed of the recent Covid-19 outbreak and received education on the importance of hand hygiene and vaccination at these meetings. The code for the front door was communicated to

residents at each meeting, and it was explained that the door had a lock to restrict unwanted entry, but residents were free to come and go as they wished. There were facilities for recreation and opportunities to engage in activities.

Regulation 10: Communication difficulties

Inspectors found that residents identified with communication difficulties had their communication needs met on assessment. They each had a detailed communication care plan in place. These care plans outlined the communication aids, tools and devices used to enable them to communicate effectively.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported in accessing and retaining control over their personal property, possessions, and finances. Residents' clothing was laundered offsite. Each resident had adequate space to store and maintain their clothes and personal possessions.

Judgment: Compliant

Regulation 17: Premises

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas required maintenance and repair to be fully compliant with Schedule 6 requirements, for example:

- Several residents did not have call bell access. The person in charge explained that following risk assessment, these residents were provided with wireless call bells; however, there were no wireless call bells available. The person in charge rectified this matter immediately.
- The flooring in the shower rooms on the north and south wings were observed to be rusted, cracked and in severe disrepair. There was a partial shower door insitu requiring replacement or repair. Additionally, there was no call bell access in some of these shower rooms should a resident need assistance.
- There was inappropriate storage seen across the residential centre which will be discussed under Regulation 27: Infection control.

- The provider did not ensure that residents could access a bath, outlined as a resident facility in the statement of purpose. One of two baths had been removed from the centre, while the second bath was not working and required repair. The current arrangements meant that residents who preferred a bath could not have one and similarly residents who could not sit in a shower chair did not have appropriate access to bathing facilities.

Judgment: Not compliant

Regulation 18: Food and nutrition

Action was required to ensure robust oversight of resident nutritional needs. This was evidenced by the following:

- Food was not prepared, or provided to residents, in line with their assessed dietary needs. For example, a resident who was prescribed a modified consistency diet was served an inappropriate diet, which posed a safety risk. This was immediately addressed during the inspection.
- While written records of each resident's dietary preferences and requirements were in place to act as a communication tool between nursing and catering staff, these systems were noted to be inaccurate and out of date. Discrepancies between records held in the kitchen by catering staff and records held in the dining area used by nursing and care staff were noted concerning three residents' nutritional needs and requirements.
- The communication systems for ensuring residents received adequate nutrition and hydration were unreliable. Inspectors observed a resident had not received support to eat their main meal or drink; however, the communication systems in place in the centre had recorded their consumption of the meal and a drink. A visitor who spoke to an inspector stated their loved one had not received a meal on two occasions in the previous eight weeks.

Judgment: Not compliant

Regulation 20: Information for residents

While the centre had a pictorial information guide for residents, it required updating to reflect the current complaints procedure and did not contain all of the requirements outlined in Regulation 20(2), for example, the terms and conditions relating to a residence in the centre.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Inspectors reviewed both the paper-based and electronic records of residents that had been transferred from the centre to acute hospital. It was not possible to verify the transfer of relevant information about the resident from the centre to the receiving hospital, such as the reason for transfer, current health status, medical diagnosis and medications, as there were no records available to review. This information is integral to ensure that the hospital is aware of all pertinent information, to provide the resident with the most appropriate medical treatment.

Judgment: Substantially compliant

Regulation 27: Infection control

While the interior of the centre was generally clean on the day of inspection, areas for improvement relating to the management of the environment and equipment were identified to ensure residents were protected from the risk of infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018) for example:

- Hand hygiene facilities were not in accordance with best practices and national guidelines. There were only a limited number of dedicated hand wash sinks in the centre. This is a repeat finding from the April 2023 inspection.
- The cleaners' store room did not contain a hand wash or janitorial sink. The cleaning staff accessed clean water and disposed of wastewater in the sluice room. This practice increased the risk of cross-contamination and was a repeat finding from the April 2023 inspection.
- Residents' clean clothing and the centre's clean linen were stored beside soiled laundry awaiting collection by an external laundry provider, representing a risk of cross-contamination. This is a repeat finding from the April 2023 and June 2022 inspections.
- Staff were manually decanting the contents of commodes/bedpans into a sluice sink before being placed in the bedpan washer for decontamination. Toilet brushes and an inverted tap were also being used. This practice increases the risk of environmental contamination and cross-infection. Bedpan washers should be capable of disposing of waste and decontaminating receptacles.
- There was brown staining within and around the sink in sluice room 1.
- Mop heads were not being laundered correctly and were observed drying on radiators beside the kitchen.
- Several bed tables were rusted and in disrepair, which impacted effective cleaning.

- Open clinical sharps bins with contents were observed in treatment room 1, which is also used as a hairdresser facility for residents. Open and overfilled open sharps bins were noted in the nurse's station. The safety mechanism was not engaged on these sharps bins, which could lead to a needle stick injury.
- Communal toiletries were observed in store room on the south wing posing a risk of cross infection from one resident to another.

Several storage practices posed a risk of cross-contamination for example:

- While the centre had a labelling mechanism to identify whether clinical equipment used by residents, including wheelchairs, hoists, mobility aids, mattresses, and weighing scales, were clean or dirty, this labelling system was inconsistently used. Therefore, it was not possible to identify if the equipment provided to a resident was clean.
- Equipment labelled as clean was being inappropriately stored. For example, a commode labelled as clean was being stored in the sluice room beside the bedpan washer, posing a risk of cross-contamination.
- Similarly, dirty equipment, such as a dirty chair scale, was being stored alongside clean equipment in the clean storeroom.
- Storage in the sluice rooms did not support effective infection prevention and control as there was no racking for bedpans and urinals.
- The storage of clinical equipment in the shower and bathroom on the south wing.
- Hoist slings and other clinical equipment were observed stored in toilets.

Judgment: Not compliant

Regulation 28: Fire precautions

Notwithstanding the good practices in place, improvements were required with respect to fire safety and fire safety management systems to protect residents in the event of fire, for example:

- While preventive maintenance records for emergency lighting were available, these records indicated several faults required repair. Inspectors sought records confirming the repairs had been made. The records provided did not prove that the multiple faults had been repaired.
- There were several large holes in the ceiling, walls and brickwork of the meter room, which contained electrical cabling and electrical storage. Other holes in this room had been filled with a substance which was not labelled as secure fire-resistant sealing. This presents a risk of fire and smoke entering and spreading from the meter room to other parts of the centre in the event of a fire.
- One oxygen cylinder was found unsecured in a store room. The other cylinders in this room were secure; however, the store room had no signage

on the door to alert people in the centre and the fire service to the presence of oxygen.
- While there was a system for weekly inspection of the fire alarm, fire doors, emergency lighting and fire fighting equipment, there were gaps in the records, and the checking appeared to rely on one person, which is not a sustainable system.
- The floor plans displayed to inform evacuation procedures in the centre but did not indicate the alternative escape routes to places of safety.
- Personal evacuation plans for residents were located in resident bedrooms and the nurses' station but required improvement. These plans did not state if the residents required supervision following an evacuation. This was important as some residents at risk of walking with purpose may attempt to re-enter the building or leave the assembly point while staff evacuated other residents.
- There were no records of lint removal from the centre's tumble dryer available for inspectors to review.

While regular fire drills were taking place, a number of improvements were required. Inspectors reviewed the last two fire drill records and noted several gaps including no reference to the:

- location of the simulated fire
- compartment that was being evacuated
- night-time or day-time staff levels used in the simulation
- number of persons evacuated during the drill and their dependency levels
- type of evacuation carried out
- time required to evacuate the compartment
- learning from the drills to ensure ongoing refinement and improvement of the fire evacuation process.

A sample of staff spoken to were knowledgeable on the procedures to follow in the event of a fire but could not identify the largest compartment in the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

While overall medication management procedures were good, further oversight of medication administration was required to ensure that best-practice guidance for medication management was followed. The inspector identified the following issues:

- The system of transcribing prescribed medications required strengthening. For example, a Kardex that had been used to administer medication had not been signed by a GP.

- The person in charge did not ensure that medicinal products were stored securely in the centre as one of the medication trolleys did not lock as the locking mechanism was broken.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical and healthcare based on their needs. Residents who required specialist medical treatment or other healthcare services, for example; chiropody, occupational therapy, dietetics and speech and language therapy, could access these services in the centre. Records reviewed by inspectors confirmed these reviews had taken place and had optimised the continued good health and well-being of residents in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors saw that staff were respectful and courteous towards residents. The provider had provided facilities for residents occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre through participation in residents meetings. Residents' privacy and dignity was respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for New Ross Community Hospital OSV-0000602

Inspection ID: MON-0041978

Date of inspection: 18/01/2024

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing ratio at night time reviewed and implemented from 26th of February 2024 to include one more staff to work twilight hours till 9 pm. The duty of this staff working the extra hour , includes conducting tea rounds and attending call bells , this facilitates the staff nurse to perform medication rounds without interruption and the two HCAs to attend the care needs of the residents .	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The staff member who completed manual handling training before commencing employment in the centre has now completed centre specific in-house manual handling training. The staff member who completed fire training outside the centre has now completed centre specific in house fire training by approved trainer who is a former fire officer. The training provided to staff by our in-house fire warden included both practical and theory sessions. Fire warden had the train the trainer certificate from an approved training company. However, all the staff who were trained by our fire warden received further in house training by an external trainer (a former fire officer) and in future all our staff members will be receiving in house fire training yearly by the external trainer. Revised Staff duty allocation record to clearly identify who is responsible for feeding the	

residents on south wing and north wing.

Meeting held with staff to ensure the person who is responsible for trays assists the residents with their meals and do not leave the resident's side until they have finished the meal and brings the tray back with them.

We have ordered epiccare touch display screen wall units for South wing and North wing for the staff so that they can enter the food ,fluid intake and other relevant resident records once they have carried out the same. Meanwhile staff will be entering this information on epiccare touch which is available on three staff tablets (available to staff for this purpose).

DON and ADON will be carrying out spot check audits and walk around at meal times to ensure that the staff are carrying out their assigned duties with diligence.

Meeting held with housekeeping staff to communicate with them about the disparity between the practice and the housekeeping record.

DON and ADON will be carrying out IPC audits to ensure the housekeeping records reflect the practice. IPC training provided to housekeeping staff on right practice. DON and ADON will be monitoring housekeeping records to ensure compliance in this regard.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All staff files reviewed post inspection and it contains full employment history with the gaps explained.

NRCH reference check document updated to include all the relevant information required for employment .

The timeframe for professional registration for nurses 2024 was until 31st January 2024 and this has now been completed and records are available in their staff files.

Regulation 23: Governance and management	Not Compliant

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

Audit and risk management training planned for DON and ADON from an approved external trainer.

Audit system reviewed and updated , to ensure that the service delivery is safe and effective. Audit system now includes action plan with time frames which will be monitored by DON.

DON and ADON planning ongoing audit and monitoring of its performance to ensure that thorough and effective quality assurance system is in place in the centre. This system includes ongoing audit and monitoring of infection prevention and control and antimicrobial stewardship performance.

Audit findings and risks will be discussed with staff and residents and education will be provided where necessary to ensure right practices and quality improvement.

DON and ADON has now completed Infection Prevention and Control Train and Trainer course.

All incidents will be notified by DoN within the required time frame to Hiqa.

Incident management training planned for nurses on 26th and 27th of March 2024 to ensure incidents are recorded properly by all staff ensuring data quality so that the incident records can be used to improve quality of service and reduce the risks for the residents.

Incidents will be monitored by DON on a weekly basis and daily where possible to ensure right practices are followed, to identify any risks and to improve quality of care for residents .

Revised Staff duty allocation record to clearly identify who is responsible for feeding the residents on south wing and north wing.

Meeting held with staff to ensure the person who is responsible for trays assists the residents with their meals and do not leave the resident's side until they have finished the meal and brings the tray back with them.

We have ordered epiccare touch display screen wall units for South wing and North wing for the staff so that they can enter the food ,fluid intake and other relevant resident records once they have carried out the same. Meanwhile staff will be entering this information on epiccare touch which is available on three staff tablets (available to staff for this purpose).

DON and ADON will be carrying out spot check audits and walk around at meal times to ensure that the staff are carrying out their assigned duties with diligence.

Meeting held with housekeeping staff to communicate with them about the disparity between the practice and the housekeeping record.

DON and ADON will be carrying out IPC audits to ensure the housekeeping records

reflect the practice. IPC training provided to housekeeping staff on right practice. DON and ADON will be monitoring housekeeping records to ensure compliance in this regard.

The centre is currently in the process of securing a contract with an approved company to carry out 6 monthly checks and remedial works to ensure our fire management system is in line with the regulation.

Carrying out monthly weight checks for residents, weekly weight checks where necessary. MUST assessment completed monthly for all residents to assess nutritional status. Referrals sent to dietitian based on resident's weight and MUST score.
Three days Food and fluid chart completed for residents to assess nutritional status of residents where necessary. Dietitian services available for all residents in the centre. Dietitian has reviewed the residents in the centre who required this service recently. Revised Staff duty allocation record to clearly identify who is responsible for feeding the residents on south wing and north wing.

Meeting held with staff to ensure the person who is responsible for trays assists the residents with their meals and do not leave the resident's side until they have finished the meal and brings the tray back with them.

We have ordered epiccare touch display screen wall units for South wing and North wing for the staff so that they can enter the food ,fluid intake and other relevant resident records once they have carried out the same. Meanwhile staff will be entering this information on epiccare touch which is available on three staff tablets (available to staff for this purpose).

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of purpose will be updated by DON to reflect the current facilities available in the centre and this will be sent to Hiqa by 1st of April 2024.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All incidents will be notified by DON to Hiqa within the required time frame.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints procedure and policy has now been updated to include role of the review officer. Also, our complaints policy now outlines the time frame for responding in writing to the complaints. DON and ADON has completed training in this regard on HSE Land.

Residents in the Centre has been informed about SAGE services available to them , also we have in house residents advocate . Also, residents have been informed about the assisted decision making act. However in 2023, none of the residents had to use SAGE advocacy services as there was no such occasions where they needed to use this

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Complaints policy has now been updated.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- Call bell audit carried out , ensured call bell available to all residents , portable / wall mounted call bell based on risk assessment. More call bells purchased for this purpose.
- Flooring in North wing shower room now being replaced by HSE (works being carried out by HSE at the moment).Plan in place for replacement of flooring in South wing shower room by HSE pending approval of funding.
-Storage ordered for storing equipments , wheelchairs etc.
-Call bell access made available to residents in the toilets/ bathrooms and shower rooms.
-Audits, spot checks and walk arounds by DON and ADON to ensure appropriate storage of items.
- 13 shower facilities available in the centre including one parker bath (this is working

and is in use) and 8 ensuite showers. Shower room which was used as storage based on risk assessment reverted back to a shower room.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
- DON has conducted a meeting with the staff , only chef and kitchen assistant to hand out meals to the HCAs and HCAs will be providing this to the residents.
- Head chef checking the dietary records with nursing staff on a weekly basis. Also, staff has been communicated to update the kitchen record whenever there is a change in the resident's modified diet / if a resident is hospitalized / temporary transfer / RIP, New resident etc.
- We have ordered epiccare touch display screen wall units for South wing and North wing for the staff so that they can enter the food ,fluid intake and other relevant resident records once they have carried out their duties in relation to this. Meanwhile, staff will be entering this information on epiccare touch which is available on three staff tablets (available to staff for this purpose). Plan in place for monthly audit by DON and ADON to ensure compliance in this regard.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
Resident information guide updated to reflect the complaints procedure and all of the requirements outlined in regulation 20 (2) , including the terms and conditions relating to residence in the centre.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

-Nurses have been communicated to complete and save national transfer summary and update nurses note on epiccare while transferring a resident to another facility , for example , hospital transfer or to another care facility, discharge to home etc.
- All the correspondences from the hospital to the centre with regards to return of the resident is filed and stored in residents brown folder under the section "correspondence".

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
-HSE has reviewed hand washing facilities in the centre and this is in their plan to upgrade the handwashing sinks in the centre pending funding .We have a total of approximately 47 handwashing facilities on the ground floor excluding laundry and kitchen . However a handwashing sink in the North wing was suggested during previous Hiqa inspection , this was risk assessed and found not suitable in the corridor for IPC reasons. There is hand washing sinks in the North wing toilet area which is available for the staff.

HSE upgrading sluice room in the North wing to include janitorial sink, works currently under progress. Following this , HSE is planning upgradation of sluice room in the South Wing.

Staff communicated to put the used bed pans and urinals with its content to the bed pan washer to ensure safe IPC practices.

Sink in the sluice room cleaned according to IPC requirement by housekeeping staff , this is included in their regular cleaning routine. Communicated with HCAS to clean the sink after each use.

Staff communicated regarding importance of following right IPC practice in relation to laundering, drying and proper storage of mop heads.

Rusted bed tables replaced ,a few repaired and painted to ensure right IPC practices.

Communicated with staff regarding importance of closing the sharps bin when it is full , storing it away and returning it .Staff were communicated regarding using sharp bins one at a time to avoid using multiple sharp bins and about the importance of proper labelling (date when it was opened and closed with signature).Sharp bin audit included in IPC audit .

Staff were communicated to ensure each resident has separate toiletries in the centre .

Staff were communicated regarding importance of adherence to the labeling system and storage of equipment, weighing chair scale and commodes in their assigned storage

space.

All the rusted equipment painted to ensure IPC adherence.

HSE upgrading sluice rooms to include adequate racking and storage in North wing, this will be followed by renovation of North wing sluice room.

Storage ordered for clinical equipment and commodes.

Staff communicated regarding appropriate storage of slings and clinical equipments.

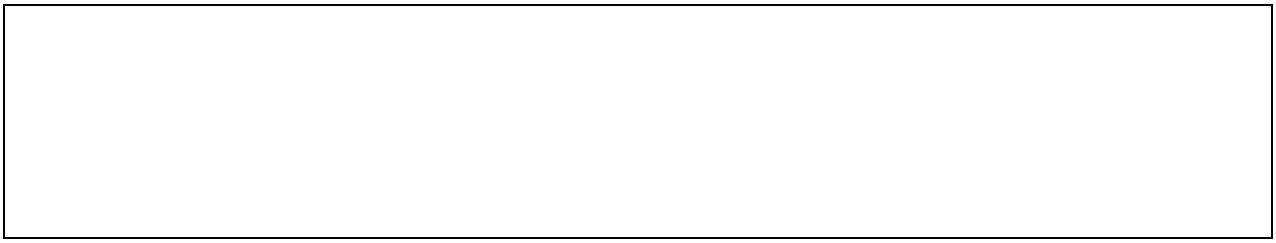
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
-Fire records updated to reflect the faults and the maintenance / repair works carried out by the fire protection consultant.

-The centre now has a contract in place with approved external fire and safety company to carry out 6 monthly inspection and remedial works. Awaiting date for the survey from the company.
-Storage ordered for safe storage of Oxygen cylinders.
- Fire Records will be completed on weekly basis by fire warden, supervised by DON. Two staff designated to carry out fire warden duties.
- Floor plans reviewed by DON to include alternate escape routes and compartments.
-PEEPS updated to include resident care needs following evacuation.
-Lint removal record created and started in practice.
-Fire drill record updated to include location of simulated fire , compartment evacuated, staffing levels used, no: of residents involved and dependency levels, type of evacuation, time required for evacuation, learning from the drill .

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
-All kardexes reviewed by DON and ADON. Medication Usage review completed by GPs.
-4 monthly review of medication and kardexes by GPs and pharmacies in place.
-Purchased new medication trolley , both medication trolleys is lockable ensuring safe storage of medications.



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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Orange	31/03/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Orange	08/03/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Not Compliant	Orange	30/04/2024

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	30/04/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	08/03/2024
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care	Not Compliant	Orange	08/03/2024

	plan of the resident concerned.			
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	21/03/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Orange	31/03/2024
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	31/03/2024
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant	Substantially Compliant	Orange	21/03/2024

	information about the resident is provided to the receiving designated centre, hospital or place.			
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.	Not Compliant	Orange	30/04/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Orange	31/03/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Orange	31/03/2024
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Orange	08/03/2024

Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Orange	08/03/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	14/03/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	14/03/2024

	detecting, containing and extinguishing fires.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Orange	14/03/2024
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Orange	08/03/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Orange	08/03/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned	Substantially Compliant	Yellow	14/03/2024

	and containing the information set out in Schedule 1.			
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	08/03/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	08/03/2024
Regulation 34(6)(b)(i)	The registered provider shall ensure that as part of the designated centre's annual review, as referred to in Part 7, a general report is provided on the level of engagement of independent advocacy services with residents.	Substantially Compliant	Yellow	21/03/2024
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable	Substantially Compliant	Yellow	14/03/2024

	training to deal with complaints in accordance with the designated centre's complaints procedures.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	08/03/2024