### Health Information and Quality Authority

**Regulation Directorate**

**Compliance Monitoring Inspection report**  
**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Brigid’s Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000672</td>
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<tr>
<td>Centre address:</td>
<td>Carrick on Suir, Tipperary.</td>
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<tr>
<td>Telephone number:</td>
<td>051 640 025</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:Ann.Guida@hse.ie">Ann.Guida@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Breda Kavanagh</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Noelene Dowling</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Paul Dunbar</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>16</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>16</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tr>
<td>19 May 2015 10:00</td>
<td>19 May 2015 19:30</td>
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<tr>
<td>20 May 2015 08:30</td>
<td>20 May 2015 16:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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<thead>
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<th>Outcome 01: Statement of Purpose</th>
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<td>Outcome 02: Governance and Management</td>
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<td>Outcome 03: Information for residents</td>
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<td>Outcome 04: Suitable Person in Charge</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<tr>
<td>Outcome 06: Absence of the Person in charge</td>
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<td>Outcome 07: Safeguarding and Safety</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 10: Notification of Incidents</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents' clothing and personal property and possessions</td>
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<td>Outcome 18: Suitable Staffing</td>
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**Summary of findings from this inspection**

The purpose of this inspection was to inform the decision of the Authority in relation to the application by the provider to register of the centre. All documentation required for the registration process was provided. The centre provides convalescent, respite and palliative care for a maximum of 16 residents. On the first day of inspection there were 14 residents and on the second day 16 residents living in the centre. The service is run and managed by the Health Service Executive (HSE).

The centre was the subject of a monitoring inspection on 3 March 2014 and had 19 non compliances. The inspector reviewed the actions outstanding following that inspection and found 13 actions had been resolved, and satisfactory actions had not
been taken on six of the findings. Actions not satisfactorily resolved included the suitability of the premises, meaningful recreation for residents, satisfactory complaints procedures and risk management procedures.

While no questionnaires were received by the authority, inspectors were informed by residents and relatives that they were very well cared for by staff who were kind, attentive and very thorough.

There was evidence that residents received a good standard of healthcare with access to a range of allied disciplines on a regular basis in the residents care and with good access to general practitioner (GP) services.

The findings of this inspection are influenced by the governance arrangements and lack of recruitment of staff in the previous years. The provider nominee had taken up post on the 24 April 2015 and no person had been nominated to support or deputise in the absence of the person in charge since July 2014. The lack of actions or planning evident on crucial issues such as the premises may be attributed to this fact.

The findings are also linked to the statement of purpose of the centre which is primarily aimed at respite convalescence and palliative care. Inspectors have taken consideration of the function of this service in assessing the provider's level of compliance.

Improvements were identified in the following areas:

- numbers, skill mix and deployment of staff
- risk assessment and management procedures
- safeguarding
- governance systems
- deputising arrangements for the absence and support of the person in charge
- failure to provide premises which are suitable for the purpose and comply with the regulations for privacy, dignity and suitable faculties for recreation or meals
- care planning
- systems to monitor the service and review the quality and safety of care
- systems implemented for learning and review
- meaningful activities or recreation for residents
- failure to forward the required notifications to the Authority
- provision of an annual report.
- records and documentation:
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The statement of purpose required some amendments to ensure it was compliant with the requirements of the regulations. These included the arrangements for residents to make complaints, the absence of the person in charge and the systems to ensure the privacy and dignity of residents. This information was revised and incorporated at the time of inspection.
Admissions to the centre and care practices were congruent

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors were not satisfied that the governance arrangements had been adequate to monitor and support the provision of care. The nominee of the provider had taken up position in the weeks prior to the inspection. The lack of actions from the previous
inspection which took place in 2014 in fundamental areas such as the provision of handrails for residents indicates that there were no clear lines of accountability for managing the centre and ensuring it was compliant with the regulations and standards.

This can be partly explained by the configuration of this centre in line with acute services as opposed to community services. The provider nominee was aware of the deficits outlined and demonstrated knowledge of her current responsibilities. There were no deputising arrangements for the person in charge.

Resources such as staffing had not been assessed and revised to ensure the delivery of care in accordance with the statement of purpose. The provider informed inspectors that she had initiated recruitment procedures for an assistant director of nursing and administrative support for the person in charge. She also stated that formal systems for reporting would be initiated which would include an increased presence in the centre.

There were no adequate systems for review of the quality and safety of care or eliciting the views of resident or relatives in this process. Two audits had been undertaken 2014, one on the admiration of medication and another on hygiene practices.

**Judgment:**
Non Compliant - Major

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**Outcome 03: Information for residents**

**A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.**

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found that there were no contracts in care in place between residents and the service provider. The person in charge advised inspectors that each resident signed a section of their care plan on admission. However, this did not give any detail on the services to be provided, and the provision for care and welfare in the centre or the fees when these may become relevant. As a number of residents stay for longer than a week and in some cases for some months an agreement for the provision of care is required.

There was a residents' guide available in the centre in the form of a booklet. The guide contained details on admissions, visits and complaints. Inspectors were satisfied that the guide met the requirements of the Regulations.

**Judgment:**
Non Compliant - Moderate
<table>
<thead>
<tr>
<th>Outcome 04: Suitable Person in Charge</th>
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<tbody>
<tr>
<td>The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.</td>
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</table>

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The person in charge was suitably qualified in nursing and post graduate training in management. She had extensive experience in clinical care and the care of older persons. She was engaged fulltime with the governance, management and administration of the centre. Both residents and staff were very familiar with her and the reporting arrangements were clear. However, it was apparent that the lack of involved senior management and the lack of suitable arrangements to deputise in her absence and support her in the day–to-day management of the centre impacted on her ability to carry out her functions.

There were some gaps evident in the knowledge of the person in charge of the responsibilities under the regulations as they apply to this designated centre. This can be partly explained by the lack of direction from the provider and the fact that the centre was not initially deemed to require registration.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
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<tbody>
<tr>
<td>The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.</td>
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**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There was a directory of residents in place in the centre. The directory did not meet the requirements of the Regulations as there were some elements missing. For example, the residents’ age as opposed to their date of birth was recorded; some residents’ next of kin information did not record an address or contact phone number; some residents’ general practitioner contact details did not contain an address or phone number; where a resident had passed away the time, date and cause of death was not recorded.

Inspectors found that that the records required by regulation in relation to residents, including assessment and care plans were not entirely complete. There were deficits in documentary care plans to outline treatment in respect of care and nursing records. Records of personal belongings were maintained and records required by Schedule 2 in relation to staff were found to be complete with some minor exceptions.

A number of policies required amendment or development. These included the risk management policy and the complaints policy. There was no record of visitors to the centre and no policy on residents’ personal property and possessions or communication with residents.

Insurance was available accordance with the HSE policy. Reports of other statutory bodies were available. Written evidence of compliance with the statutory fire authority had been forwarded to the Chief Inspector as part of the application for registration.

**Judgment:**
Substantially Compliant

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**Outcome 06: Absence of the Person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were informed that there had been no periods of leave by the person in charge which would have necessitated notification to the Authority. The provider was aware of the requirement to make this notification in the event that such an absence occurred. However, the provider had made no satisfactory arrangements to cover the absence of the person in charge since the retirement of the assistant director of nursing in July 2014. This is actioned under outcome 2 Governance and Management.

**Judgment:**
Compliant
**Outcome 07: Safeguarding and Safety**

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspectors were satisfied that resident’s safety and welfare was prioritised with some improvements required in relation to methods of restraint. The person in charge and staff stated that there had been no incidents of alleged, suspected or reported abuse. The new HSE national policy on the Protection of Vulnerable Adults was available in the centre. The person in charge confirmed that she had not received training in the implementation of this policy or her role as the designated officer as yet. She was knowledgeable as to how she would manage any allegation however.

Training records reviewed indicated that not all staff had attended education and training on the protection of vulnerable residents and two staff informed inspectors that they had not had this training. One of these was catering and household staff who said it was not practice for them to undertake this training.

Staff spoken with demonstrated an understanding of their own responsibilities in relation to the protection of residents and signs and symptoms of abuse which would indicate concern however. They also expressed their confidence in the person in charge to act on any concerns which may arise. They understood the avenues to take should the management not act responsibly.

Inspectors were informed that the provider was not acting as agent for any residents and no monies were being deposited in accounts on behalf of residents. As this is a short term care facility payment is required only for stays which go beyond 30 days in accordance with the HSE policy. Such fees were invoiced and paid either by the resident or their representative and receipted.

Residents and relatives with whom inspectors spoke stated that they felt very safe and spoke positively about the care and consideration they received. Residents described the staff as being readily available to them if they had any concerns or needs. There was a centre-specific policy on the management of challenging behaviours. This was not a significant feature of the service and there were guidelines in place for staff to follow. Staff were observed to be responsive and patient with residents at all times during the inspection. There was evidence of multidisciplinary referral to psychiatry of old age where this was deemed necessary.
Methods of restraint or restrictive practices were not used as matter of course. However, there were two conflicting policies in place. Where bedrails were used there was an assessment tool available to inform the decision. From a review of a number of these tools inspectors found that practice was inconsistent.

In some instances the contra-indication for bedrail use such as the risk of a resident being agitated or confused resulted in a decision not to use the bedrails. In other instances the rails were used despite the contra-indications and there was no clarity available as to the rationale behind this deviation from the policy. The systems were not satisfactory reviewed. There was no evidence of alternative methods being tried prior to the use of the rails.

Relatives were also required to sign consent for the use of the bedrails on behalf of the residents which is not in accordance with the national policy and guidelines. A review of medication charts indicated that Pro-re-nata (as required) medication was not used for restrictive purposes.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 08: Health and Safety and Risk Management</strong></th>
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<tbody>
<tr>
<td><strong>The health and safety of residents, visitors and staff is promoted and protected.</strong></td>
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</table>

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Some but not all of the issues indentified at the previous inspection had been addressed. There was a health and safety statement which was current and signed. The risk management policy had been reviewed and included the management of hazards and the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. The inspector viewed risk registers which identified hazards such as slips, trips and falls, residents who may wander and manual handling risks, with controls aimed at reducing such hazards. The emergency plan had been devised as required and this included systems for transporting and relocating residents which were in line with the HSE crisis management plan. There were guidelines for staff to follow in the event of loss of power and emergency numbers were available. The risk manage policy did not however contain any actions to prevent or manage incidents of self harm.

The infection control policy was detailed and systems for prevention of infection were evident. Staff were observed taking appropriate precautions, using protective equipment...
and household staff outlined good cleaning and preventative systems. Hand hygiene equipment was readily available in all areas of the centre. Clinical waste was managed appropriately and all such items stored securely.

Individual risk assessments were completed for residents in relation to falls or wandering. Where falls or other incidents had occurred the inspector found that appropriate medical review was sought promptly. Where it was deemed necessary additional actions such as censor tags or bed alarms were used if residents were at risk of wandering.

The systems for learning from and review of incidents were not implemented. Incidents were, as per the policy forwarded to the clinical risk manager. A review of the accident and incident reports did not consistently demonstrate that incidents were audited for trends/timing or contributory factors and satisfactory control measures implemented. For example, a resident using an alerting alarm exited via the front door and was missing from the centre. The alarm only sounded when the door opened as opposed to on approach to the door. Therefore the resident had ample time to exit the centre. In that instance the resident was located without undue harm. The alarm system had not been reviewed or replaced to ensure staff would be alerted prior to the resident leaving the centre.

Working and serviced call-bells were in place and inspectors observed that these were placed within easy reach of the residents. However, there was a dependence on residents to be able to use the call-bell and in some instances records showed that residents did not remember this and experienced a fall. Staff noted this but no actions were taken to address it.

In practice all risks identified were not consistently responded to with control measures. For example, the stairs had been correctly identified in the risk register by the person in charge due to its location in the wards and the dependency or capacity of the residents. The remedial action to be taken was that residents considered at risk of a fall down the stairs be moved to the single bedroom nearest the nurses’ station. However, inspector observed and staff confirmed that on occasions it was necessary to closely supervise residents who may inadvertently access the stairs and fall. Given the staffing levels at certain times this was not always possible.

The risk assessment of residents who smoked had not been addressed and appropriate supportive measures put in place as required by the previous inspection.

Core safely features such as hand rails on corridors and walking areas required at the previous inspection had not been provided.

Some of the exit doors including fire exits were safely managed via coded locks. However, the front door was not. This allowed full unrestricted access into the premises. The ground floor contains the three palliative care bedrooms, the office of the person in charge and the kitchen. There are no staff assigned to this section. As observed by inspectors from 17:30hrs at night this area is devoid of staff. This could result in unauthorised person’s people being able to access the very vulnerable residents on this floor without anyone’s knowledge.
Fire safety management systems in terms of servicing of equipment were found to be satisfactory but improvements were required in staff training and the holding of fire drills at suitable intervals to ensure staff were familiar with them. One staff had not undergone fire training and no practice drills had been held outside of the training.

Documentation confirmed that the fire alarm and emergency lighting was serviced quarterly and other equipment serviced annually as required. Daily checks on the exit doors and the fire panel were recorded.

Some but not all staff were familiar with the fire safety procedures. There were no personal evacuation plans for any resident who would require significant support to be evacuated from the first floor. A specialist piece of equipment was available for this purpose but one senior staff informed inspectors she did know how to use this.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Medication Management**
Each resident is protected by the designated centre’s policies and procedures for medication management.

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Current policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the prescribing, receipt of, management, administration, storage and accounting for medication were satisfactory. There were appropriate documented procedures for the handling, disposal of and return of medication. There was evidence on records that medication was reviewed monthly or more often for individual residents. Staff were prompt in monitoring and reporting any adverse affects concerning medication.

Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation. Actions required from the previous inspection included the maximum dosage of medications administered on a PRN (pro re nata or 'as required') and lockable fridge for medication and these were satisfactorily resolved. Also the prescription sheets now contained a photograph of the resident and the signature of the prescriber was present when medications were discontinued.

The usual length of stay varies and the residents at the time of inspection had a length of stay of between one and twelve weeks. Practice in the management of medication and prescriptions which residents brought from home were found to be satisfactory. The process for reviewing medication once every three months by the medical officer did not
apply to these residents but the inspector saw that the general practitioners reviewed medication on an ongoing basis such as on a re-admission or after a prolonged stay.

**Judgment:**
Compliant

**Outcome 10: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found that the person in charge had not complied with the responsibility to forward the required notifications to the Chief Inspector. No notifications had been received from the person in charge since January 2014.

**Judgment:**
Non Compliant - Major

**Outcome 11: Health and Social Care Needs**
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
From a review of eight residents medical and care records inspectors were satisfied that the residents’ health care needs were met to a good standard and that they were consulted and supported in relation to their needs and wishes. Some improvements were requires in the documentation of care pans and in planning for residents communication or dementia care needs. Up to four GPs provide medical care to the residents and these GPs also share the out-of-hour’s service thereby ensuing consistency of care.
Despite the short stay nature of the service there was evidence of frequent access to allied services such as chiropody, tissue viability specialists, dieticians and physiotherapy which was available on site to all residents regardless of status. A large number of residents were admitted following stays in acute care, some with significant post operative care needs. Inspectors found that staff were knowledgeable and had sufficient clinical training to deliver care to these residents.

There were systems in place to ensure that satisfactory information on admission and discharge from hospital or re-admission from home was available. This included a report from the residents GP and from the family member. Nursing assessments were revised to take account of any changes since the previous admission. Staff ensured residents had all necessary vaccinations.

Inspectors saw that evidenced based assessment tools were used for risk of falls, nutrition and pressure areas. There was evidence that residents and relatives were actively involved in these assessments. However, the outcome of all assessments undertaken did not result in a corresponding care plan to manage the issue identified. In some instances residents were deemed to be at high risk of developing pressure areas or falls. There was no corresponding care plan outlined.

The action required from the previous inspection was in relation to the documentation of wound care and specifically the use of diagrams or photographs to identify and monitor the progression or improvement.

While there was evidence that such care was carried out the documentation was again unclear and in some instances staff were unable to clarify the nature or grading of the wound. Some photographs had been taken but they were not, as per the HSE policy on the management of wounds in the resident files. Some photographs were only available on camera and not viewable as an adequate means of assessment.

There were no communication needs identified in any plans seen despite some residents having communication difficulties. While the initial admission information contained basic social information in relation to residents social care needs these were not considered in care planning.

While improvements were required in the documentation of care plans to address the issues identified, from a review of the comprehensive nursing notes the inspectors were satisfied that this deficit was primarily in documentation and that the health care required for residents was delivered to a good standard. This is actioned under Outcome 18 Documentation. The improvements which are required concern the psychosocial and communication needs of residents and are pertinent even to a short stay facility.

Inspectors found that there was significant pressure on all staff in particular nursing staff to carry out their duties given the level of dependency of the residents and the number of admissions and discharges to be managed in a given day. This is actioned under Outcome 18 Workforce.

Judgment:
Non Compliant – Moderate

**Outcome 12: Safe and Suitable Premises**
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The premises pose significant challenges to the provider in meeting the needs of resident and complying with the regulations. It is a 200yr old three story building. Resident accommodation is located on the ground floor and first floor. The offices of the person in charge and the administrator are located on the ground floor. The nurses’ station is located on the first floor. The second floor has a large physiotherapy room, staff changing facilities, shower, staff dining area and general storage rooms. The building contains a fully serviced lift between all of the floors.

Residents accommodation on the ground floor comprises of three single palliative care rooms. Each palliative care room has en suite facilities with an assisted shower, toilet and wash-hand basin as well as a seating area and kitchenette for visitors. These rooms all have doors leading onto the back garden.

On the first floor there are two five-bedded rooms, one two-bedded room and a single room. There are three toilets, one shower and a sluice room. The centre was well maintained bright, clean and hygienic.

The sluice room contained appropriate equipment and facilities. There was sufficient assistive equipment in place and adequate storage was available. The premises were heated and well decorated. There was a suitable kitchen and food storage and preparation areas in place. Records demonstrated that equipment such as heating, lifts, hoists and specialist beds were serviced regularly and kept in working order.

A significant number of non compliances were evident in the premises which impacted on the quality of life and the privacy and dignity and quality of life of residents:

- There was no communal day or dining space for residents.
- There were two five bedded wards measuring 40sq metres. These did not provide adequate space for personal possessions.
Privacy and dignity were impacted upon. One bed in the five bedded rooms could not be accessed with equipment such as a hoist if required without encroaching on the space of other residents and ensuring the privacy screening could be maintained.

- There were no wardrobes available for residents clothing
- There was an insufficient number of showers on the first floor for the number of residents with one shower to 13 residents.
- The shower door was broken
- Access to a number of toilets was limited and residents had to be transported via commode as the wheelchairs could not be used.

Notwithstanding that the centre aims to provide primarily short term respite and convalescent care the lack of space for any function or even quiet time outside of the wards is not satisfactory. In reality records indicated that residents stay for far longer than a week or two if awaiting a long term care facility.

**Judgment:**
Non Compliant - Major

**Outcome 13: Complaints procedures**
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The centre maintained a record of complaints received from residents or family members. Inspectors reviewed the log and found that complaints were responded to promptly and investigated thoroughly. However, there was one complaint that did not record whether or not the complainant was satisfied with the outcome of the complaint.

The centre did not have the complaints procedure in a prominent place in the centre. The centre relied on the Health Service Executive's 'Your Service, Your Say' complaints procedure. However, it was unclear from the local policy who was the designated complaints officer. The policy identified the director of nursing, CNM2 or deputy as a person who could investigate a complaint. In addition, there was also no person delegated to ensure that complaints are responded to and appropriately recorded.

**Judgment:**
Non Compliant - Moderate
**Outcome 14: End of Life Care**

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

**Theme:**

Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There was a detailed policy on end-of-life care. The centre has three dedicated palliative care suites although in reality residents who require palliative care support may also be accommodated in the main wards if the suites are not available. Nursing staff had undergone training in palliative care and health care assistants had also undergone end of life care training. There was very good support evident from external palliative care specialists.

From a review of the records of a number of residents who had passed away there was evidence that residents care, comfort and support was prioritised at this time. Relatives were supported and facilitated to remain overnight and the suites have a kitchenette and sitting room attached.

However, there was no documented evidence that residents wish including treatment or admission to acute care facilities in the event of illness. There was no differentiation between the generic care plans and the palliative care plans. For example, there were no care plans for symptom management such as pain relief or other measures necessary to provide comfort. There were brief notes in the nursing records that palliative care was the treatment option but this was not consistent.

There was also no care plan which dealt with residents emotional social psychological or spiritual needs at this time. From speaking with residents inspectors ascertained that they were informed and consulted. While this is again primarily a documentation failure the statement of purpose defines a specific role for palliative care service in the centre and such planning is integral to this function.

The records showed that residents comfort at end of life had been prioritised, the records were written in a respectful manner and families kept informed of any changes. However, the records were not complete. In some instances they did not detail when the resident’s remains left the centre or if the death had been verified. The person in charge stated that the mortuary in the centre is not used and the residents remains leave the centre usually within a few hours as and when the families can make arrangements. There were lists of residents personal possessions maintained so that they could be returned to the next of kin.

**Judgment:**
Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were centre specific detailed policies in place for the monitoring and documentation of nutrition and hydration. Residents were weighed on admission and monthly or weekly depending on the reason for admission and the length of stay. Evidenced based assessment tools were used to monitor nutritional status. There was evidence that prompt referral to dieticians or speech and language therapists were made as required.

Resident’s food preferences and needs were documented on admission and clearly communicated to the catering staff that were found to be both knowledgeable and facilitative of their preferences and specific dietary requirements. Inspectors observed that the instructions of the speech and language therapist were clearly documented in relation to modified consistency diets or fortified diets and these were seen to be adhered to by staff.

From a review of a sample of care plans undertaken there were records of relevant monitoring with regard to nutrition and weight and fluid intake. Any nutritional supplements were appropriately prescribed by the residents GP and records showed that these were administered. Residents were encouraged to take fluids and these were observed to be available. Soups, bovril and snacks were readily available.

Residents may have their breakfast in bed. However, due to the lack of any dining space all residents have their meals on chairs using bed tables by their beds which are not conducive to a positive dining experience although the staff were observed trying to make it so. Residents were assisted slowly and with dignity.

Residents with whom the inspectors spoke expressed high levels of satisfaction with the quality and quantity of the food and the fact that meals and snacks were available at any time.

The food was all freshly prepared. The catering staff had training in food hygiene and appropriate food safety management systems were in place.

Judgment:
Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
All of the residents who spoke with inspectors were complimentary about the manner in which they were treated by staff. Inspectors observed that all interactions between staff and residents were carried out in a respectful manner. Residents also advised that they were in a position to exercise choice in the centre. For example, residents could choose when they wished to get out of or go to bed. Choice was also available in terms of meals and snacks in the centre. A visiting priest attends at the centre fortnightly.

Residents had access to local and national newspapers and there were televisions available throughout the centre. Inspectors spoke to a number of residents' relatives who advised that there were no restrictions in terms of visiting times. However, there was no area within the centre in which residents could meet with visitors in private or spend quiet time alone apart from the palliative care rooms.

There were no opportunities for recreation provided for residents except the daily papers and television. While this is partly influenced by the lack of facilities other than the wards and bedrooms the person in charge also stated that they did not view this as part of the function in a short term centre of this type. However, as the findings in other outcomes indicates some residents spend considerable time either receiving palliative care or awaiting long stay care placements and some are recuperating. Residents did say that the days were very long. Although there was a garden to the rear of the premises inspectors were informed that residents in the first floor could only access this if family members were available to bring them down to it.

The person in charge advised that there were no arrangements in place for people who wished to exercise their voting rights as this cannot be arranged in short a term facility. However, residents who wished to travel outside of the centre to exercise their vote could do so with the support of family or friends for transportation depending on their health care needs at the time.

While in this instance it may not be suitable to hold residents meetings there was no
other system considered to ascertain the views of resident or relatives in regard to the running of the centre.

Inspectors were not satisfied that each resident's privacy and dignity was respected within the centre. The multi-occupancy rooms did not provide for an environment in which residents could be cared for in a dignified way. Inspectors observed that on admission a resident sat with a nurse in the ward while the admission process was being carried out. This involved discussing personal and private information.

Furthermore, three bedrooms had CCTV cameras in operation which allowed full view of the residents in bed or moving around their rooms. There was a policy available and residents or relatives had signed consent for its use in the bedrooms. From observation it was apparent that the cameras were intrusive and that it was used to supplement staff as a means of supervision for residents. Both the lack of recreation and the CCTV cameras had been actioned at the previous inspection but no changes had been made to the systems.

**Judgment:**
Non Compliant - Major

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**Outcome 17: Residents' clothing and personal property and possessions**

**Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.**

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied that residents' personal property was kept safe through appropriate record keeping. The centre maintained a property log for all new admissions. The log detailed all residents' clothing and personal items and a copy of the log was provided to the resident or their family. The centre also had a locked safe for valuable items and residents’ were given the option of storing items in the safe.

There were no laundry facilities on site in the centre. The person in charge informed inspectors that this was because the centre was a short stay/convalescence service. However, according to the records in the centre, there were some residents who had been residing there for more than three months. Staff advised inspectors that such residents' had to rely on family or friends to do their laundry. This may not be possible for some residents and no contingency plan was available should this be the case.

**Judgment:**
Non Compliant - Moderate
**Outcome 18: Suitable Staffing**

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**

Workforce

**Outstanding requirement(s) from previous inspection(s):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

Inspectors were not satisfied that the numbers of staff available were suitable to meet the assessed needs of the residents due primarily to the size and layout of the premises. There were two registered nurses on duty at all times with two health care assistants up to 14:00 and one thereafter until 20:45hrs.

The number of admissions on a day, which can be up to three also impacts on the staffing ratios. An admission from acute care can take considerable time as observed by the inspectors. In one instance observed by inspectors a resident required the attention of both nurses and for a time the care assistant in the evening time. This effectively left all other residents unsupervised. From 20:45hrs two nurses were on duty with no care attendants.

While the ratio of patients to staff overnight and in the evening may appear to be satisfactory the layout of the premises, the clinical care needs of the residents which includes palliative care indicates this is not sufficient. Ten of the residents on the day of inspection were assessed as requiring full assistance and nursing care. The CCTV camera is in effect being used to monitor residents in an area where staff are not deployed on the ground floor.

Training records reviewed demonstrated that manual handling training had been completed for all staff, two staff did not have up to date fire training and two staff did not have training in the protection of vulnerable adults. Other pertinent training had been provided including palliative care, medication management, food safety and management of sharps. The majority of the care assistant staff had Further Education and Training Awards Council (FETAC) level five training.

Staff meetings were held irregularly and there was no system of staff supervision implemented.

A review a sample of personal files indicated that the provider was in substantial
compliance with all the required documentation available with one minor exception.

Staff were observed to be kind respectful, knowledgeable on their respective functions, very supportive of the residents and copies of relevant guidance was available at the centre.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Brigid’s Hospital</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000672</td>
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<tr>
<td>Date of inspection:</td>
<td>19/05/2015</td>
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<td>Date of response:</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not satisfactory resourced in terms of staffing and support for the person in charge.

Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Management systems were not satisfactory to ensure the service was appropriate safe and monitored.

**Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
A CNM2 post has been approved and is in the process of being filled. The post holder will deputise for the Person in Charge, when necessary, when they are in post.

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There is no system for compiling the annual review of the quality and safety of care and which includes the views of residents.

**Action Required:**
Under Regulation 23(d) you are required to: Ensure 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.

**Please state the actions you have taken or are planning to take:**
The Quality and Safety of Care delivered to residents at St. Brigid’s Hospital will be reviewed on an ongoing basis to ensure that care meets with relevant standards. A local group comprising of Nurse Management from the 3 Short Stay Units in Tipperary i.e. Cluain Arann, St. Brigid’s and St. Theresa’s will be established, supported by Ms. Margaret Foley Practice Development Coordinator to review and audit the quality of
service delivery in all three facilities.

All patients will be issued with a questionnaire, which they will be asked to complete prior to their discharge. This questionnaire will facilitate in ascertaining patients/carers views on care which they received in St. Brigid’s Hospital.

Proposed Timescale: Process has commenced-Ongoing

Proposed Timescale: 07/07/2015

Outcome 03: Information for residents
Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There are no contracts of care in place for residents.

Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
A Contract of Care has been developed.

Proposed Timescale: 07/07/2015

Outcome 05: Documentation to be kept at a designated centre
Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no policy on residents’ personal property and possessions or communication with residents.
Policies on complaints and risk management required amendments.
There were two separate polices on the management of restrictive practices.

Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(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.
Please state the actions you have taken or are planning to take:
The Complaints policy has been updated.

Work has commenced in developing the following policies:
• A residents personal property and possessions policy
• A residents communication policy

Work has commenced in the reviewed and amendment of the Risk management policies

Both policies on restrictive practice are being reviewed and updated and amalgamated into one policy

**Proposed Timescale:** 30/09/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some of the information required by Schedule 3 of the Regulations is absent from the directory of residents.

**Action Required:**
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

**Please state the actions you have taken or are planning to take:**
Enteries into the Directory are now in compliance with Regulations.

Proposed Timescale: Commenced and Ongoing

**Proposed Timescale:** 07/07/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The records required by regulation in relation to residents, including assessment and care plans were not entirely complete. There were deficits in documentary care plans to outline treatment in respect of care and nursing records.

**Action Required:**
Under Regulation 21(1) you are required to: 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.
Please state the actions you have taken or are planning to take:
Care Plans have been reviewed and staff members have been informed of the requirements in relation to completion and improvements are being implemented.

Proposed Timescale: Commenced and Ongoing

**Proposed Timescale:** 07/07/2015

### Outcome 07: Safeguarding and Safety

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of restrictive practices such as bed rails was not in line with National policy and satisfactorily monitored.

**Action Required:**
Under Regulation 07(3) you are required to: 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.

Please state the actions you have taken or are planning to take:
St. Brigid’s Hospital policy on Restrictive Practice has been reviewed to ensure that it is in compliance with national policy.
Current restraint practice have been reviewed and discussed at unit meetings to ensure compliance.
The use of Bedrails will be in compliance with the policy on Restrictive practice. Bed rails will not be used, where contra indicated.

Proposed Timescale: Commenced and ongoing

**Proposed Timescale:** 07/07/2015

### Outcome 08: Health and Safety and Risk Management

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not cover a number of risks within the centre and the precautions in place to control these risks. This includes the risk of self harm.

**Action Required:**
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
A meeting was held with the Clinical Risk Manager on Tuesday 16th June. The purpose of the meeting was to review risk management policies within St. Brigid’s Hospital to ensure all known potential risks are included within the Risk Management policy.

Proposed Timescale: 30/09/2015
Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not cover the precautions in place to control the risk of self-harm.

Action Required:
Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
A meeting was held with the Clinical Risk Manager on Tuesday 16th June. The purpose of the meeting was to review risk management policies within St. Brigid’s Hospital to ensure all known potential risks including measures and actions to control self harm form part of the Risk Management policy.

Proposed Timescale: 30/09/2015
Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of risks did not have adequate measures in place to prevent injury and following incidents there was no satisfactory learning from adverse events; This includes but is not limited to:

- risk from the stairs
- risk assessment of residents who smoked
- access by unauthorised persons
- residents leaving the centre in an unsafe manner
- lack of core safety features including hand rails.
**Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
A meeting was held with the Clinical Risk Manager on Tuesday 16th June. The purpose of the meeting was to review risk management policies within St. Brigid’s Hospital to ensure all known potential risks are included within the Risk Management policy. The views of Technical Services has been sought to address issues such as safe guarding the stairs and access and egress to and from the building. A Stair gate will be put in place at both ends of the stairs to reduce the potential for patients at risk accessing it. It will equally allow staff members’ easy access from ground to first floor. CCTV cameras have been installed at the main entrance. Hand rails are now in place in patient areas.

**Proposed Timescale:** 30/09/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no regular fire drills being carried out in the centre.

**Action Required:**
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
Fire Training has been contracted out to Private Providers who have been contacted with a view to obtaining specific dates to Fire Training. A Fire Drill was completed week of the 22nd June.

**Proposed Timescale:** 31/10/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no personal emergency evacuation procedures in place for residents.

**Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

**Please state the actions you have taken or are planning to take:**
Fire Training has been contracted out to Private Providers who have been contacted with a view to obtaining specific dates to Fire Training.
The views of the Clinical Risk Manager and Technical Services have also been sought in order to establish adequate arrangements for evacuating, where necessary in the event of fire, all persons in St. Brigid’s Hospital and safe placement of residents.

**Proposed Timescale:** 31/10/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all staff had updated fire safety training and all staff were not familiar with the fire evacuation procedures.

**Action Required:**
Under Regulation 28(1) (d) you are required to: 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.

**Please state the actions you have taken or are planning to take:**
Fire Training has been contracted out to Private Providers who have been contacted with a view to allocating specific dates to Fire Training.

**Proposed Timescale:** 31/10/2015

**Outcome 10: Notification of Incidents**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Notifications which required a three day report to the Chief Inspector had not been forwarded.

**Action Required:**
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4
within 3 working days of its occurrence.

**Please state the actions you have taken or are planning to take:**
This will be actioned with immediate effect.

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**Proposed Timescale:** 07/07/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Notifications which required quarterly return to the Chief inspector had not been forwarded.

**Action Required:**
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

**Please state the actions you have taken or are planning to take:**
This will be actioned with immediate effect.

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**Proposed Timescale:** 07/07/2015

**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no adequate care plans to inform practice on the needs of residents with communication difficulties or dementia.

**Action Required:**
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

**Please state the actions you have taken or are planning to take:**
All Care plans are under review. Clarity will be provided in Care Plans, where necessary on the clinical management of communication difficulties and dementia.

**Proposed Timescale:** Ongoing
Proposed Timescale:

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Documentation of wounds and progress was not in accordance with national guidance.

**Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cráimhseachais.

**Please state the actions you have taken or are planning to take:**
All care plans are currently being reviewed. Documentation of wound care will be brought in line with national guidelines

Proposed Timescale: Ongoing

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**Proposed Timescale:**

**Outcome 12: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
- There was no communal day or dining space for residents.
- There were two five bedded wards. These did not provide adequate space for personal possessions.
- One bed in the five bedded rooms could not be accessed with equipment such as a hoist if required without encroaching on the space of other residents and ensuring the privacy screening could be maintained.
- There were no wardrobes available for residents clothing
- There was an insufficient number of showers on the first floor for the number of residents with one shower to 13 residents.
- The shower door was broken
- Access to a number of toilets was limited and residents had to be transported via commode as the wheelchairs could not be used.

**Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.
Please state the actions you have taken or are planning to take:

Short term:
Phase 1: A Day room, Dining Room and second Nurses station will be developed on the ground floor of St. Brigid’s Hospital (Space currently allocated to the Director of Nursing/Administrative staff member and hallway). The Director of Nursing and Administrative staff member will be relocated to the second floor.
Phase 2: An evacuation lift and En-suite for to one of the 5 bedded rooms converting it into a 4 bedded room.
Phase 3: The development of an extension on the flat roof over the palliative suite rooms and thus creating another 4 bedded ensuite room with sitting room.
The practice of planning patient location will continue. No patient who requires a hoist transfer will be placed in the middle bed of the 5 bedded rooms on the first floor
Additional storage space will be made available in the 2-bedded room.
The broken shower door on the 1st floor as been replaced.

Medium Term:
Consideration will be given to the location of all short stay accommodation to one central Location in South Tipperary i.e. in Our Lady’s Campus. Should this decision be taken neither Phase 2 or 3 advised above, will be developed at St. Brigid’s Hospital.

Proposed Timescale: Phase 1 will be completed by end of December 2015. No time frame can be given in relation to the completion of Phase 2 and 3 as their completion will be dependent on the availability of Capital funding.

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no complaints procedure in a prominent place in the centre.

Action Required:
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
Notice boards have been put in prominent positions and will allow information to be more accessible for patients and relatives. Details of the complaints procedure has be posted on the notice board.

Proposed Timescale: 07/07/2015
Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no person appointed to ensure that complaints are appropriately responded to and recorded.

Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
The Director of Nursing is the nominated person to respond to complaints in an appropriate manner and is responsible for maintaining the records specified in Regulation 34 (1) (f).

Proposed Timescale: Commenced and ongoing

Proposed Timescale: 07/07/2015
Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One complaint reviewed did not record whether the complainant was satisfied with the outcome.

Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
With immediate effect, the Director of Nursing will maintain a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Proposed Timescale: 07/07/2015

Outcome 14: End of Life Care
Theme: Person-centred care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans did not adequately demonstrate that residents physical emotional psychological and spiritual needs and wishes of the resident were planned for and addressed.

Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
Care plans are currently being reviewed and going forward they will demonstrate that residents’ physical, emotional, psychological and spiritual needs and wishes are planned for and addressed.

Proposed Timescale: Commenced and ongoing

Proposed Timescale: 07/07/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no recreation or activation for residents in the centre.

Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
Board games and card games can be implemented with immediate effect. The introduction of other activities will occur when the Day room is developed.

Proposed Timescale: Immediate and ongoing

Proposed Timescale: 07/07/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of CCTV cameras in some bedrooms intruded on areas where residents could reasonably expect privacy.

**Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
CCTV cameras were removed on 21/05/2015

| **Proposed Timescale:** 07/07/2015 |
| **Theme:** Person-centred care and support |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no systems for residents to voice their opinions on the routines or organisation of the centre..

**Action Required:**
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

**Please state the actions you have taken or are planning to take:**
Respite patients and families will be asked if they would like to be part of a residents committee. All patients will be issued with a questionnaire, which they will be asked to complete prior to their discharge. This questionnaire will facilitate in ascertaining patients/carers views on care which they received in St. Brigid’s Hospital.

Proposed Timescale: Commenced and ongoing

| **Proposed Timescale:** 07/07/2015 |
| **Theme:** Person-centred care and support |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no private space available where residents could meet with visitors.

**Action Required:**
Under Regulation 11(1) you are required to: Make arrangements for a resident to receive visitors.

**Please state the actions you have taken or are planning to take:**
If Patients/Relatives express a wish to have private meetings they are accommodated
and this will continue into the future.

**Proposed Timescale:** 07/07/2015

## Outcome 17: Residents' clothing and personal property and possessions

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no provisions in place for residents' laundry needs should this be necessary.

**Action Required:**
Under Regulation 12(b) you are required to: Ensure each resident’s linen and clothes are laundered regularly and returned to that resident.

**Please state the actions you have taken or are planning to take:**
Laundry is centralised in St Luke in Clonmel. As St. Brigid’s Hospital is a short stay, families are requested to take laundry home. Infection control practice would be compromised if personal laundry was done on site. However if a patient has a specific issue with their laundry then that will be addressed on a case by case basis.

**Proposed Timescale:** Ongoing

## Outcome 18: Suitable Staffing

**Theme:**
Workforce

**Proposed Timescale:** 07/07/2015
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number and skill mix of staff was not satisfactory to ensure the safe delivery of care at all times taking the needs of residents and the Statement of Purpose into account.

Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Twilight MTA hours equating to 1.25 additional staff members have been approved. An additional MTA will be employed from 5.30pm to 11.30pm each evening. There will thus be 4 staff members up to 8.30 and 3 staff members employed up to 11.30. Once the 2nd Nurses Station is established on the ground floor, there will be a staff presence on both ground and 1st floor for the majority of the time.

Proposed Timescale: Commenced and Ongoing

Proposed Timescale: 07/07/2015
Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff did not have the required mandatory training.

Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
Staff members have received Fire, Manual Handling and CPR training. This training will be ongoing. Fire Training dates are currently being sourced. Behavioural Support Training is being sourced externally.

Proposed Timescale: 31/12/2015
Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no supervision process for staff.
**Action Required:**
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
A format for staff supervision has been developed and the requirement for supervision will be advised at the next staff meeting.
Staff meetings will be held on more regular basis.

**Proposed Timescale:** 30/09/2015